

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04927					04920				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
PAUL P. ADLER					APRIL 27, 1969				
3. SEX MALE					2b. HOUR 6:30 AM				
4. RACE WHITE					6. AGE (In years last birthday) 49 YRS.				
5. DATE OF BIRTH 9/19/19					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH BALTIMORE Md.				
10. CITY OR TOWN OF DEATH FORT HOWARD					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL				
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SOCIAL WORKER					12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. CITY OR TOWN BALTIMORE				
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 1701 EUTAW PLACE				
14. FATHER'S NAME First Middle Last MOSES - - ADLER					15. MOTHER'S MAIDEN NAME First Middle Last SARAH - - PLANT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16b. SOCIAL SECURITY NO. 212 01 6635				
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF									
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CEREBRAL VASCULAR DISEASE									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from APR 22, 1969, to APR 27, 1969, that (we) saw the deceased alive on APR 27, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Philip M. Ashman DEGREE									
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. DATE SIGNED 4/27/69									
22d. PHYSICIAN'S NAME (Type) PHILIP M. ASHMAN, M.D.									
22e. ADDRESS VAH, FT. HOWARD, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL									
23b. DATE 4/28/1969									
23c. NAME OF CEMETERY OR CREMATORY BALTO. HEBREW CONG. CEM.									
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.									
24. FUNERAL DIRECTOR SYLVAN LEWIS FUNERAL HOME GARRISON, MD.									
25a. RECEIVED BY REGISTRAR APR 29 1969									
25b. REGISTRAR'S SIGNATURE									

04327

PAUL  
WHITE  
MAILED  
U.S.A.  
RAILROAD  
FORT HOWARD  
MAILED  
PLANT

WILL  
SIS OF 2025 CLINICAL RECORDS, VAN, E. HOWARD, MD.  
MYOCARDIAL INFARCTION  
ARTERIOVENOUS DISEASE  
CHRONIC VASCULAR DISEASE

PHILIP M. REIDMAN, M.D.  
VAN, E. HOWARD, MD.  
BUREAU  
HISHER CORP. CORP.  
Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
04928		CERTIFICATE OF DEATH						04921				
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
MAUDE			EVELYN			ALISEA			04 Month 15 Day Year 69 2:55 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAU		6-02-04			64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md.		U.S.A.					BALTIMORE CO. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON, MARYLAND			GRTR. BALTO. MED CNTR			Clerk			Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.					Balto.				1026 W. 38th St.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
?			?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
no			213-03-6378A			Erma Jackson 1355 W. 42nd St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										IMMEDIATE		
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) <u>CA OF LUNG, BRAIN METASTASIS</u>										6 MONTHS		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> , 19 <u>69</u> , to <u>4-15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>B.R. Choi M.D.</u>										4-15-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
B.R. CHOI M.D.												
23a. BURIAL, CREMATION, (specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial		4/17/69		St. Mary's				Balto. Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Paul E. Chenoweth 3rd. 3617 Chestnut Ave.						APR 17 1969		<u>Charles Judge</u>				

06038

RECORDS OF DEATH

219-0-0078 THE RECORDS 1922 W. 1922 U.

Initial

2/1/22

1. 1922

1. 1922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04929										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04922			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR			
MARSHALL C. ANDREWS										Month 4 Day 30 Year 69										6:20 P M			
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Male		White		April 15, 1882						87 YRS.		MONTHS		DAYS									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH															
Ohio		U.S.A.		WIDOWED		DIVORCED		Baltimore		Md.													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Rockyville				Masonic Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Ohio				Cleveland				YES		NO		4250 W. 33rd Street											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
John Andrews				Isabelle Robertson																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address											
Yes, no, or unknown				271-07-2789				Masonic Home Records															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Cerebral Hemorrhage														Months									
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														10 yrs.									
(b) Arterio-sclerotic Vas. Heart Dis																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
								YES				NO											
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)															
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. Month Day Year																			
(If either, notify medical examiner)				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION				City or Town County State											
While <input type="checkbox"/> Not while <input type="checkbox"/>								Street or R.F.D. No.															
at work <input type="checkbox"/> at work <input type="checkbox"/>																							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1926, to April 30, 1969, that (I) (we) last saw the deceased alive on April 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE														22c. DATE SIGNED									
Carl F. Benson, M.D.														4/30/69									
22d. PHYSICIAN'S NAME (Type)														22e. ADDRESS									
Carl F. Benson, M.D.														5111 York Rd Balt. Md 21212									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				5-3-1969				Druid Ridge Cemetery				Pikesville Md.											
24. FUNERAL DIRECTOR				ADDRESS				25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Wm. Cook-Brooks Towson				1050 York Rd Towson Md 21204				MAY 6 1969				James Judge											

04358

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
STANLEY LEWIS ANSELL					MATED <input type="checkbox"/> 4 16 1969					2:15
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	OCT 27, 1926		42 YRS.	MONTHS DAYS HOURS MIN.				Month April Day 16 Year 19 69	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNA.		USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Woodlawn		Milford Mill & Liberty Heights				TRUCK DRIVER		DRIVER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		CARROLL		New Windsor				Box 177 New Windsor, Md.		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
ELMER					JANE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
YES		WW II		179-20-9361		RUTH ANSELL NEW WINDSOR MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 815.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
		2:15 4 16 19 69		Subject driver in truck-fixed object coll.						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
		Street		Milford Mill & Liberty Heights		Balto.		Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		4/16/69		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		APRIL 19-1969		EVERGREEN GARDENS		FINKSBURG				MD
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
D.D. Hartzler & Sons		New Windsor				DATE APR 18 1969		J. Charles Judge		



STATE OF NEW YORK  
JUDICIAL DEPARTMENT

00030

IN SENATE  
JANUARY 18, 1966  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		JAN 4, 1968		MEMPHIS, TENN.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF MEDICAL EXAMINER		TITLE	
MEMPHIS, TENN.		ATTORNEY AT LAW		HEART DISEASE		NATURAL		JAMES EARL RAY		M.D.	
FAMILY PHYSICIAN		HOSPITAL		POST MORTEM		TOXICOLOGY		FORENSIC PATHOLOGY		OTHER	
DR. JAMES EARL RAY		MEMPHIS, TENN.		NO		NO		NO		NO	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESS		TITLE		OTHER	
JAN 18, 1968		10:00 AM		MEMPHIS, TENN.		JAMES EARL RAY		M.D.		OTHER	

James Earl Ray

100-18-1866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (4)  
304M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
GRACE Pearl			ARMACOST			Apr. Month 13 Day		Year 1969 8 45 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		Cauc.		March 1, 1889		80 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Balto.		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Monkton			York Rd.			Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Balto.			Monkton		York Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James Almony			Elista Standiford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			212-28-3461A			Mrs. Thelma E. Knouse, Parkton, MD 21120			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4122									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1950, to 4/13, 1969, that (I) (we) last saw the deceased alive on 4/10/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.M. France MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69		
22d. PHYSICIAN'S NAME (Type) A.M. FRANCE					22e. ADDRESS PARKTON, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/16/69		Fosters Cemetery		Monkton-Balto-Md.			
24. FUNERAL DIRECTOR James J. Hartenstein, New Freedom, Pa.					25a. REC'D BY REGISTRAR DATE APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

1. [Illegible]

2. [Illegible]

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100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Harry N. Armacost</i>			2a. DATE OF DEATH Month Day Year <i>4 5 69</i>			2b. HOUR <i>9:04 AM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Feb. 15, 1886</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>House In The Pines-Catonsville</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Funeral Director</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4204 Ridgewood Avenue</i>	
14. FATHER'S NAME First Middle Last <i>Ellsworth Armacost</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i><del>Dora</del> Annie I. Newnam</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-36-3379</i>		17. INFORMANT Address <i>Marion P. Armacost-4600 Liberty Hghts. Av</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ch. Myocarditis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2108</i> <i>837</i> <i>837</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-18</i> , 19 <i>69</i> , to <i>4-5</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-4</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wilmer K. Gallagher, Sr. MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>4-7-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, Sr. MD</i>					22e. ADDRESS <i>2209 Sandwick Ave Balt Md 21228</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-8-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Armacost Funeral Chapel-4600 Liberty Hghts</i>				25a. REC'D BY REGISTRAR <i>APR. 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Mr. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
04933									
04926									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. TIME
John Forrest ASH						April Month 9 Day 1969 Year			11:30 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		Jan. 1, 1920			49 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Oklahoma		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Fort Howard			Veterans Administration Hospital			Guard			Detective Agency
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland					Baltimore				843 Glade Court
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Kenneth Ash			Pauline Kean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) WW-11			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			314 05 41 80		Clinical Rcds, VA Hospital, Fort Howard, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar 26, 19 69, to April 9, 19 69, that <input checked="" type="checkbox"/> (I/we) last saw the deceased alive on April 9, 19 69, and that in <input checked="" type="checkbox"/> (my/our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did/did not) view the body after death.									
22b. SIGNATURE J. D. Talbert, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/10/69			
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.				22e. ADDRESS VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR 1930 Eastern Ave. Balto, Md.			25b. REGISTRAR'S SIGNATURE APR 15 1969		
FISHER FUNERAL HOME									

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FOR STATE  
HEALTH DEPT.

04934

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04927

DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR M	
DURWOOD		O.		ASHWORTH							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
male	white	1-20-1914		54 55 YRS.						April 28, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				10. HOUR	
Virginia		U.S.A.				Baltimore				10:40 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph's Hospital		Cost Analyst		Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore		Govans				405 Croydon Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Lawrence Wellington Ashworth								Maude Ashworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				718-16-8275		Mrs. Lillian Ashworth		405 Croydon Rd. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		4/28/69	
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-2-1969		Westhampton Memorial Park		Richmond, Virginia					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson 1050 York Road 21204						MAY 1 1969		Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

45620

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04935

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04928

1. DECEASED-NAME (Type or print)		First <b>RICHARD</b>	Middle <b>A.</b>	Lost <b>AVARITT SR.</b>	2a. DATE OF DEATH Month <b>4/</b> Day <b>30/</b> Year <b>69</b>		2b. HOUR <b>9:25AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11/3/26</b>		6. AGE (In years last birthday) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>		Md.		
10. CITY OR TOWN OF DEATH <b>PORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHIPYARD</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>474 Cornell Road</b>		
14. FATHER'S NAME First <b>Ollie</b> Middle <b>AVARITT</b> Lost <b>AVARITT</b>		15. MOTHER'S MAIDEN NAME First <b>MAMIE</b> Middle <b>DOMBROWSKI</b> Lost <b>DOMBROWSKI</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give year or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>218 22 58 70</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSP. FT HOWARD, MD.</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) <b>CIRRHOSIS OF LIVER</b> stating the underlying cause (c) last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) this hospital attended the deceased from <b>4/26/69</b> , 19____, to <b>4/30/69</b> , 19____, that (X) (we) last saw the deceased alive on <b>4/30/69</b> , 19____, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John D. Talbert M.D.</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/30/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>					22e. ADDRESS <b>VAH FT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL, OR OTHER <b>BURIAL</b>		23b. DATE <b>5/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILLS CEMETERY</b>		23d. LOCATION (City or Town) <b>BALTIMORE, MD.</b>		(County) (State)		
24. FUNERAL DIRECTOR <b>JOHN J. DUDA FUNERAL HOME</b>					ADDRESS <b>7922 WISE AVENUE, DUNDALK, MD.</b>		REC'D BY REGISTRAR <b>2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



04337

REPORT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04936		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04929	
1. DECEASED-NAME (Type or print)		First Middle Last Ella AYERS (AYRES)		2a. DATE OF DEATH 4 Month 26 Day 69 Year	
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH July 21, 1885	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		6. AGE (In years lost birthday) 83 YRS.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto	
14. FATHER'S NAME First Middle Last William Curtis		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Ann		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO	
16b. SOCIAL SECURITY NO. 215-07-1506D		17. INFORMANT Mrs. Margaret O'Meara		17b. ADDRESS 7918 Dunhill Village Baltimore Md. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>longstanding heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>cardiovascular accident, Right hemiplegia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE E. Kasaitis, M.D.		22c. DATE SIGNED 4/26/69	
22d. PHYSICIAN'S NAME (Type) E. KASAITIS, M.D.		22e. ADDRESS 1801 Funderburg Rd Baltimore Md 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 30, 69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
24. FUNERAL DIRECTOR Loung Byers		ADDRESS Liberty Rd.		25a. REC'D BY REGISTRAR APR 30 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
04937																				
04930																				
1. DECEASED-NAME (Type or print)			First Orville			Middle H.			Last Aylor			2a. DATE OF DEATH April Month 21 Day 69Year			2b. HOUR 4:58 P M					
3. SEX Male			4. RACE White			5. DATE OF BIRTH 4-20-1882			6. AGE (In years last birthday) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md.											
10. CITY OR TOWN OF DEATH Balto. 12			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holly Hill Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Gov't. Printing, Retired			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Balto. 10			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4 Hillside Rd. 21210								
14. FATHER'S NAME Robert			First H.			Middle Aylor			15. MOTHER'S MAIDEN NAME Anna Virginia Childs			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-50-7069			17. INFORMANT Richard H. Wood			Address 4 Hillside Rd. 21210											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastric ulcer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 25 1968</u> , to <u>APRIL</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>APRIL</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>Joseph D.B. King</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED APRIL 22 1969							
22d. PHYSICIAN'S NAME (Type) JOSEPH D.B. KING										22e. ADDRESS 2 HAMILL Road - BALTO. Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE April 24, 1969			23c. NAME OF CEMETERY OR CREMATORY Beahms Chapel			23d. LOCATION (City or Town) (County) (State) Luray Va.											
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.										4905 York Road Balto 21212, Md			25a. REC'D BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE J Charles Jager				

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RECEIVED BY DEPT. OF HEALTH  
HOSPITALS DIVISION  
JAN 10 1950



NAME	JOHN J. HARRIS
AGE	45
SEX	M
RACE	W
RELIGION	R
EDUCATION	H
OCCUPATION	DRIVER
RESIDENCE	1234 5th Ave, New York 17, N.Y.
DATE OF BIRTH	10-15-1904
DATE OF DEATH	
CAUSE OF DEATH	
PLACE OF DEATH	
DATE OF BURIAL	
PLACE OF BURIAL	
DATE OF EXAMINATION	
PLACE OF EXAMINATION	
DATE OF INTERVIEW	
PLACE OF INTERVIEW	
DATE OF REPORT	
PLACE OF REPORT	

*John J. Harris*  
1234 5th Ave, New York 17, N.Y.

RECEIVED BY DEPT. OF HEALTH  
HOSPITALS DIVISION  
JAN 10 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Marie</i>			First <i>M</i> Middle <i>Azzarello</i> Last			2a. DATE OF DEATH Month <i>APRIL</i> Day <i>6</i> Year <i>69</i>		2b. HOUR <i>8:40 AM</i>		
3. SEX <i>F</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>5-03-09</i>		6. AGE (In years lost birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>				
10. CITY OR TOWN OF DEATH <i>Randallstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto. County General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Randalls.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 190A Liberty Rd.</i>	
14. FATHER'S NAME First <i>Santo</i> Middle <i>Azzarello</i> Last			15. MOTHER'S MAIDEN NAME First <i>Kattie</i> Middle <i>nmi</i> Last <i>Palmisano</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Balto. County General Hospital</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.V.A.</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPER TENSION.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Acute Myocardium Infarction.</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 5</i> , 19 <i>69</i> , to <i>APRIL 6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>APRIL 6</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Boon Vanasin</i>		DEGREE <i>BOON VANASIN</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>April 6, 69</i>				
22d. PHYSICIAN'S NAME (Type) <i>BOON VANASIN</i>		22e. ADDRESS <i>Balto. County Gen. Hosp.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/6/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>				
24. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd. Randallstown</i>		25a. REC'D BY REGISTRAR <i>APR 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. J. J.</i>				

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STATE OF DEAN

THE UNIVERSITY OF CHICAGO



Office: 6734 Lincoln Rd., Northbrook, Ill. 60062  
Phone: (708) 465-1000  
Fax: (708) 465-1001  
E-mail: [info@chicagolib.org](mailto:info@chicagolib.org)  
Web: <http://www.chicagolib.org>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04939

CERTIFICATE OF DEATH

04932

1. DECEASED-NAME (Type or print) <i>Harry Norman Baetjer</i>			2a. DATE OF DEATH <i>April</i> Month <i>Day 5</i> Year <i>69</i>			2b. HOUR <i>4:38</i> M					
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>JAN. 12. 1882</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.					
10. CITY OR TOWN OF DEATH <i>Stevenson</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>-</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lawyer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Practo</i>		13c. CITY OR TOWN <i>Stevenson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Valley Road</i>		
14. FATHER'S NAME First <i>JOHN</i> Middle <i>GEORGE</i> Last <i>BAETJER</i>			15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>ANNA</i> Last <i>KOPPLEMAN</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>213-34-1406</i>		17. INFORMANT Address <i>Mrs. Lenora Hartley, Stevenson, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF <i>A.S.C.V.P.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>3 years</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>17 Jan</i> , 19 <i>67</i> , to <i>5 April</i> , 19 <i>68</i> , that (II) (we) last saw the deceased alive on <i>3 June</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles H. Williams</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-5-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i>						22e. ADDRESS <i>Pikeville, 21268, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>APRIL 7, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE Md.</i>					
24. FUNERAL DIRECTOR <i>HENRY W. JENKINS &amp; SONS. Co. 4905 YORK ROAD.</i>						25a. REC'D BY REGISTRAR DATE <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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RECEIVED

APR 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04940									
CERTIFICATE OF DEATH									
04933									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George			Lotes Baldwin			April 5, 1969			2:40 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
male		white		Aug. 15, 1886		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		U.S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			engineer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Pr. Geol.		Adelphi		YES		9250 Edwards Way
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George P. Baldwin			Annie Martha Ann Scott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			577-36-7938		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1969</u> , to <u>April 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
<u>Rafael H. Marin</u>		4-5-69			Rafael H. Marin, M.D.				
22e. ADDRESS		22f. ADDRESS							
SPRING GROVE STATE HOSPITAL		Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4/9/69		Cedar Hill Cem.			Suitland, Md.		
24. FUNERAL DIRECTOR		24a. ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Nalley's Funeral Home Inc.		Mt. Rainier, Maryland			APR 11 1969		Charles Judge		

04240

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

IN SENATE,  
January 12, 1921.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1920.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1921.

Price, 10 CENTS.

By Order of the Senate,  
JAMES B. LEECH, STATE PRINTER.

Approved by the Senate,  
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JAMES B. LEECH, STATE PRINTER.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

04941

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04934

1. DECEASED-NAME (Type or Print)		First Joseph		Middle Bales		Last Bales		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year ESTIMATED <input type="checkbox"/> <b>Apr. 21</b> 19 <b>69</b>				2b. HOUR 11:05 AM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 10, 1906		6. AGE (in years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>April 21</b> 19 <b>69</b>				2d. HOUR 11:30 AM	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2925 Salisbury Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-Bethlehem Steel Co.				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2925 Salisbury Ave.					
14. FATHER'S NAME First Middle Last Paul Bales		15. MOTHER'S MAIDEN NAME First Middle Last Anna ?													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 070-10-4876		17. INFORMANT (Daughter) ADDRESS Edgemere, Md. Mrs. Rita Maranovich, 3102 River Drive Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Theodore C. Patterson</u>				M.D. Theodore C. Patterson M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/22/69 3724 Dundalk Ave. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/24/69				23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.								25a. REC'D BY REGISTRAR DATE APR 25 1969				25b. REGISTRAR'S SIGNATURE Charles Judge			

100-2-10  
100-2-10

04347

RECORD OF INVESTIGATION FOR THE DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE

Name of Subject		Date of Birth		Place of Birth	
John Doe		10-10-1900		New York, N.Y.	
Occupation		Education		Religion	
Sales		High School		Catholic	
Address		City		State	
123 Main St.		New York		N.Y.	
Telephone		Room		County	
123-4567		100		New York	
Social Security		Maiden Name		Married Name	
123-456789		Jane Doe		John Doe	
Previous Addresses		Previous Occupations		Previous Employers	
456 Elm St., New York, N.Y.		Salesman		ABC Company, New York, N.Y.	
789 Oak St., New York, N.Y.		Clerk		XYZ Company, New York, N.Y.	
101 Pine St., New York, N.Y.		Manager		PQR Company, New York, N.Y.	
123 Maple St., New York, N.Y.		Owner		RST Company, New York, N.Y.	
145 Birch St., New York, N.Y.		Partner		UVW Company, New York, N.Y.	
167 Cedar St., New York, N.Y.		Director		XYZ Company, New York, N.Y.	
189 Elm St., New York, N.Y.		President		ABC Company, New York, N.Y.	
210 Maple St., New York, N.Y.		Vice President		DEF Company, New York, N.Y.	
232 Oak St., New York, N.Y.		Secretary		GHI Company, New York, N.Y.	
254 Pine St., New York, N.Y.		Assistant		JKL Company, New York, N.Y.	
276 Birch St., New York, N.Y.		Manager		MNO Company, New York, N.Y.	
298 Cedar St., New York, N.Y.		Owner		PQR Company, New York, N.Y.	
320 Elm St., New York, N.Y.		Partner		STU Company, New York, N.Y.	
342 Maple St., New York, N.Y.		Director		VWX Company, New York, N.Y.	
364 Oak St., New York, N.Y.		President		YZA Company, New York, N.Y.	
386 Pine St., New York, N.Y.		Vice President		BCD Company, New York, N.Y.	
408 Birch St., New York, N.Y.		Secretary		EFG Company, New York, N.Y.	
430 Cedar St., New York, N.Y.		Assistant		HIJ Company, New York, N.Y.	
452 Elm St., New York, N.Y.		Manager		KLM Company, New York, N.Y.	
474 Maple St., New York, N.Y.		Owner		NOP Company, New York, N.Y.	
496 Oak St., New York, N.Y.		Partner		QRS Company, New York, N.Y.	
518 Pine St., New York, N.Y.		Director		TUV Company, New York, N.Y.	
540 Birch St., New York, N.Y.		President		WXY Company, New York, N.Y.	
562 Cedar St., New York, N.Y.		Vice President		ZAB Company, New York, N.Y.	
584 Elm St., New York, N.Y.		Secretary		CDE Company, New York, N.Y.	
606 Maple St., New York, N.Y.		Assistant		FGH Company, New York, N.Y.	
628 Oak St., New York, N.Y.		Manager		IJK Company, New York, N.Y.	
650 Pine St., New York, N.Y.		Owner		LMN Company, New York, N.Y.	
672 Birch St., New York, N.Y.		Partner		OPQ Company, New York, N.Y.	
694 Cedar St., New York, N.Y.		Director		RST Company, New York, N.Y.	
716 Elm St., New York, N.Y.		President		UVW Company, New York, N.Y.	
738 Maple St., New York, N.Y.		Vice President		XYZ Company, New York, N.Y.	
760 Oak St., New York, N.Y.		Secretary		ABC Company, New York, N.Y.	
782 Pine St., New York, N.Y.		Assistant		DEF Company, New York, N.Y.	
804 Birch St., New York, N.Y.		Manager		GHI Company, New York, N.Y.	
826 Cedar St., New York, N.Y.		Owner		JKL Company, New York, N.Y.	
848 Elm St., New York, N.Y.		Partner		MNO Company, New York, N.Y.	
870 Maple St., New York, N.Y.		Director		PQR Company, New York, N.Y.	
892 Oak St., New York, N.Y.		President		STU Company, New York, N.Y.	
914 Pine St., New York, N.Y.		Vice President		VWX Company, New York, N.Y.	
936 Birch St., New York, N.Y.		Secretary		YZA Company, New York, N.Y.	
958 Cedar St., New York, N.Y.		Assistant		BCD Company, New York, N.Y.	
980 Elm St., New York, N.Y.		Manager		EFG Company, New York, N.Y.	
1002 Maple St., New York, N.Y.		Owner		HIJ Company, New York, N.Y.	
1024 Oak St., New York, N.Y.		Partner		KLM Company, New York, N.Y.	
1046 Pine St., New York, N.Y.		Director		NOP Company, New York, N.Y.	
1068 Birch St., New York, N.Y.		President		QRS Company, New York, N.Y.	
1090 Cedar St., New York, N.Y.		Vice President		TUV Company, New York, N.Y.	
1112 Elm St., New York, N.Y.		Secretary		WXY Company, New York, N.Y.	
1134 Maple St., New York, N.Y.		Assistant		ZAB Company, New York, N.Y.	
1156 Oak St., New York, N.Y.		Manager		CDE Company, New York, N.Y.	
1178 Pine St., New York, N.Y.		Owner		FGH Company, New York, N.Y.	
1200 Birch St., New York, N.Y.		Partner		IJK Company, New York, N.Y.	
1222 Cedar St., New York, N.Y.		Director		LMN Company, New York, N.Y.	
1244 Elm St., New York, N.Y.		President		OPQ Company, New York, N.Y.	
1266 Maple St., New York, N.Y.		Vice President		RST Company, New York, N.Y.	
1288 Oak St., New York, N.Y.		Secretary		UVW Company, New York, N.Y.	
1310 Pine St., New York, N.Y.		Assistant		XYZ Company, New York, N.Y.	
1332 Birch St., New York, N.Y.		Manager		ABC Company, New York, N.Y.	
1354 Cedar St., New York, N.Y.		Owner		DEF Company, New York, N.Y.	
1376 Elm St., New York, N.Y.		Partner		GHI Company, New York, N.Y.	
1398 Maple St., New York, N.Y.		Director		JKL Company, New York, N.Y.	
1420 Oak St., New York, N.Y.		President		MNO Company, New York, N.Y.	
1442 Pine St., New York, N.Y.		Vice President		PQR Company, New York, N.Y.	
1464 Birch St., New York, N.Y.		Secretary		STU Company, New York, N.Y.	
1486 Cedar St., New York, N.Y.		Assistant		VWX Company, New York, N.Y.	
1508 Elm St., New York, N.Y.		Manager		YZA Company, New York, N.Y.	
1530 Maple St., New York, N.Y.		Owner		BCD Company, New York, N.Y.	
1552 Oak St., New York, N.Y.		Partner		EFG Company, New York, N.Y.	
1574 Pine St., New York, N.Y.		Director		HIJ Company, New York, N.Y.	
1596 Birch St., New York, N.Y.		President		KLM Company, New York, N.Y.	
1618 Cedar St., New York, N.Y.		Vice President		NOP Company, New York, N.Y.	
1640 Elm St., New York, N.Y.		Secretary		QRS Company, New York, N.Y.	
1662 Maple St., New York, N.Y.		Assistant		TUV Company, New York, N.Y.	
1684 Oak St., New York, N.Y.		Manager		WXY Company, New York, N.Y.	
1706 Pine St., New York, N.Y.		Owner		ZAB Company, New York, N.Y.	
1728 Birch St., New York, N.Y.		Partner		CDE Company, New York, N.Y.	
1750 Cedar St., New York, N.Y.		Director		FGH Company, New York, N.Y.	
1772 Elm St., New York, N.Y.		President		IJK Company, New York, N.Y.	
1794 Maple St., New York, N.Y.		Vice President		LMN Company, New York, N.Y.	
1816 Oak St., New York, N.Y.		Secretary		OPQ Company, New York, N.Y.	
1838 Pine St., New York, N.Y.		Assistant		RST Company, New York, N.Y.	
1860 Birch St., New York, N.Y.		Manager		UVW Company, New York, N.Y.	
1882 Cedar St., New York, N.Y.		Owner		XYZ Company, New York, N.Y.	
1904 Elm St., New York, N.Y.		Partner		ABC Company, New York, N.Y.	
1926 Maple St., New York, N.Y.		Director		DEF Company, New York, N.Y.	
1948 Oak St., New York, N.Y.		President		GHI Company, New York, N.Y.	
1970 Pine St., New York, N.Y.		Vice President		JKL Company, New York, N.Y.	
1992 Birch St., New York, N.Y.		Secretary		MNO Company, New York, N.Y.	
2014 Cedar St., New York, N.Y.		Assistant		PQR Company, New York, N.Y.	
2036 Elm St., New York, N.Y.		Manager		STU Company, New York, N.Y.	
2058 Maple St., New York, N.Y.		Owner		VWX Company, New York, N.Y.	
2080 Oak St., New York, N.Y.		Partner		YZA Company, New York, N.Y.	
2102 Pine St., New York, N.Y.		Director		BCD Company, New York, N.Y.	
2124 Birch St., New York, N.Y.		President		EFG Company, New York, N.Y.	
2146 Cedar St., New York, N.Y.		Vice President		HIJ Company, New York, N.Y.	
2168 Elm St., New York, N.Y.		Secretary		KLM Company, New York, N.Y.	
2190 Maple St., New York, N.Y.		Assistant		NOP Company, New York, N.Y.	
2212 Oak St., New York, N.Y.		Manager		QRS Company, New York, N.Y.	
2234 Pine St., New York, N.Y.		Owner		TUV Company, New York, N.Y.	
2256 Birch St., New York, N.Y.		Partner		WXY Company, New York, N.Y.	
2278 Cedar St., New York, N.Y.		Director		ZAB Company, New York, N.Y.	
2300 Elm St., New York, N.Y.		President		CDE Company, New York, N.Y.	
2322 Maple St., New York, N.Y.		Vice President		FGH Company, New York, N.Y.	
2344 Oak St., New York, N.Y.		Secretary		IJK Company, New York, N.Y.	
2366 Pine St., New York, N.Y.		Assistant		LMN Company, New York, N.Y.	
2388 Birch St., New York, N.Y.		Manager		OPQ Company, New York, N.Y.	
2410 Cedar St., New York, N.Y.		Owner		RST Company, New York, N.Y.	
2432 Elm St., New York, N.Y.		Partner		UVW Company, New York, N.Y.	
2454 Maple St., New York, N.Y.		Director		XYZ Company, New York, N.Y.	
2476 Oak St., New York, N.Y.		President		ABC Company, New York, N.Y.	
2498 Pine St., New York, N.Y.		Vice President		DEF Company, New York, N.Y.	
2520 Birch St., New York, N.Y.		Secretary		GHI Company, New York, N.Y.	
2542 Cedar St., New York, N.Y.		Assistant		JKL Company, New York, N.Y.	
2564 Elm St., New York, N.Y.		Manager		MNO Company, New York, N.Y.	
2586 Maple St., New York, N.Y.		Owner		PQR Company, New York, N.Y.	
2608 Oak St., New York, N.Y.		Partner		STU Company, New York, N.Y.	
2630 Pine St., New York, N.Y.		Director		VWX Company, New York, N.Y.	
2652 Birch St., New York, N.Y.		President		YZA Company, New York, N.Y.	
2674 Cedar St., New York, N.Y.		Vice President		BCD Company, New York, N.Y.	
2696 Elm St., New York, N.Y.		Secretary		EFG Company, New York, N.Y.	
2718 Maple St., New York, N.Y.		Assistant		HIJ Company, New York, N.Y.	
2740 Oak St., New York, N.Y.		Manager		KLM Company, New York, N.Y.	
2762 Pine St., New York, N.Y.		Owner		NOP Company, New York, N.Y.	
2784 Birch St., New York, N.Y.		Partner		QRS Company, New York, N.Y.	
2806 Cedar St., New York, N.Y.		Director		TUV Company, New York, N.Y.	
2828 Elm St., New York, N.Y.		President		WXY Company, New York, N.Y.	
2850 Maple St., New York, N.Y.		Vice President		ZAB Company, New York, N.Y.	
2872 Oak St., New York, N.Y.		Secretary		CDE Company, New York, N.Y.	
2894 Pine St., New York, N.Y.		Assistant		FGH Company, New York, N.Y.	
2916 Birch St., New York, N.Y.		Manager		IJK Company, New York, N.Y.	
2938 Cedar St., New York, N.Y.		Owner		LMN Company, New York, N.Y.	
2960 Elm St., New York, N.Y.		Partner		OPQ Company, New York, N.Y.	
2982 Maple St., New York, N.Y.		Director		RST Company, New York, N.Y.	
3004 Oak St., New York, N.Y.		President		UVW Company, New York, N.Y.	
3026 Pine St., New York, N.Y.		Vice President		XYZ Company, New York, N.Y.	
3048 Birch St., New York, N.Y.		Secretary		ABC Company, New York, N.Y.	
3070 Cedar St., New York, N.Y.		Assistant		DEF Company, New York, N.Y.	
3092 Elm St., New York, N.Y.		Manager		GHI Company, New York, N.Y.	
3114 Maple St., New York, N.Y.		Owner		JKL Company, New York, N.Y.	
3136 Oak St., New York, N.Y.		Partner		MNO Company, New York, N.Y.	
3158 Pine St., New York, N.Y.		Director		PQR Company, New York, N.Y.	
3180 Birch St., New York, N.Y.		President		STU Company, New York, N.Y.	
3202 Cedar St., New York, N.Y.		Vice President		VWX Company, New York, N.Y.	
3224 Elm St., New York, N.Y.		Secretary		YZA Company, New York, N.Y.	
3246 Maple St., New York, N.Y.		Assistant		BCD Company, New York, N.Y.	
3268 Oak St., New York, N.Y.		Manager		EFG Company, New York, N.Y.	
3290 Pine St., New York, N.Y.		Owner		HIJ Company, New York, N.Y.	
3312 Birch St., New York, N.Y.		Partner		KLM Company, New York, N.Y.	
3334 Cedar St., New York, N.Y.		Director		NOP Company, New York, N.Y.	
3356 Elm St., New York, N.Y.		President		QRS Company, New York, N.Y.	
3378 Maple St., New York, N.Y.		Vice President		TUV Company, New York, N.Y.	
3400 Oak St., New York, N.Y.		Secretary		WXY Company, New York, N.Y.	
3422 Pine St., New York, N.Y.		Assistant		ZAB Company, New York, N.Y.	
3444 Birch St., New York, N.Y.		Manager		CDE Company, New York, N.Y.	
3466 Cedar St., New York, N.Y.		Owner		FGH Company, New York, N.Y.	
3488 Elm St., New York, N.Y.		Partner		IJK Company, New York, N.Y.	
3510 Maple St., New York, N.Y.		Director		LMN Company, New York, N.Y.	
3532 Oak St., New York, N.Y.		President		OPQ Company, New York, N.Y.	
3554 Pine St., New York, N.Y.		Vice President		RST Company, New York, N.Y.	
3576 Birch St., New York, N.Y.		Secretary		UVW Company, New York, N.Y.	
3598 Cedar St., New York, N.Y.		Assistant		XYZ Company, New York, N.Y.	
3620 Elm St., New York, N.Y.		Manager		ABC Company, New York, N.Y.	
3642 Maple St., New York, N.Y.		Owner		DEF Company, New York, N.Y.	
3664 Oak St., New York, N.Y.		Partner		GHI Company, New York, N.Y.	
3686 Pine St., New York, N.Y.		Director		JKL Company, New York, N.Y.	
3708 Birch St., New York, N.Y.		President		MNO Company, New York, N.Y.	
3730 Cedar St., New York, N.Y.		Vice President		PQR Company, New York, N.Y.	
3752 Elm St., New York, N.Y.		Secretary		STU Company, New York, N.Y.	
3774 Maple St., New York, N.Y.		Assistant		VWX Company, New York, N.Y.	
3796 Oak St., New York, N.Y.		Manager		YZA Company, New York, N.Y.	
3818 Pine St., New York, N.Y.		Owner		BCD Company, New York, N.Y.	
3840 Birch St., New York, N.Y.		Partner		EFG Company, New York, N.Y.	
3862 Cedar St., New York, N.Y.		Director		HIJ Company, New York, N.Y.	
3884 Elm St., New York, N.Y.		President		KLM Company, New York, N.Y.	
3906 Maple St., New York, N.Y.		Vice President		NOP Company, New York, N.Y.	
3928 Oak St., New York, N.Y.		Secretary		QRS Company, New York, N.Y.	
3950 Pine St., New York, N.Y.		Assistant		TUV Company, New York, N.Y.	
3972 Birch St., New York, N.Y.		Manager		WXY Company, New York, N.Y.	
3994 Cedar St., New York, N.Y.		Owner		ZAB Company, New York, N.Y.	
4016 Elm St., New York, N.Y.		Partner		CDE Company, New York, N.Y.	
4038 Maple St., New York, N.Y.		Director		FGH Company, New York, N.Y.	
4060 Oak St., New York, N.Y.		President		IJK Company, New York, N.Y.	
4082 Pine St., New York, N.Y.		Vice President		LMN Company, New York, N.Y.	
4104 Birch St., New York, N.Y.		Secretary		OPQ Company, New York, N.Y.	
4126 Cedar St., New York, N.Y.		Assistant		RST Company, New York, N.Y.	
4148 Elm St., New York, N.Y.		Manager		UVW Company, New York, N.Y.	
4170 Maple St., New York, N.Y.		Owner		XYZ Company, New York, N.Y.	
4192 Oak St., New York, N.Y.		Partner		ABC Company, New York, N.Y.	
4214 Pine St., New York, N.Y.		Director		DEF Company, New York, N.Y.	
4236 Birch St., New York, N.Y.		President		GHI Company, New York, N.Y.	
4258 Cedar St., New York, N.Y.		Vice President		JKL Company, New York, N.Y.	
4280 Elm St., New York, N.Y.		Secretary		MNO Company, New York, N.Y.	
4302 Maple St., New York, N.Y.		Assistant		PQR Company, New York, N.Y.	
4324 Oak St., New York, N.Y.		Manager		STU Company, New York, N.Y.	
4346 Pine St., New York, N.Y.		Owner		VWX Company, New York, N.Y.	
4368 Birch St., New York, N.Y.		Partner		YZA Company, New York, N.Y.	
4390 Cedar St., New York, N.Y.		Director		BCD Company, New York, N.Y.	
4412 Elm St., New York, N.Y.		President		EFG Company, New York, N.Y.	
4434 Maple St., New York, N.Y.		Vice President		HIJ Company, New York, N.Y.	
4456 Oak St., New York, N.Y.		Secretary		KLM Company, New York, N.Y.	
4478 Pine St., New York, N.Y.		Assistant		NOP Company, New York, N.Y.	
4500 Birch St., New York, N.Y.		Manager		QRS Company, New York, N.Y.	
4522 Cedar St., New York, N.Y.		Owner		TUV Company, New York, N.Y.	
4544 Elm St., New York, N.Y.		Partner		WXY Company, New York, N.Y.	
4566 Maple St., New York, N.Y.		Director		ZAB Company, New York, N.Y.	
4588 Oak St., New York, N.Y.		President		CDE Company, New York, N.Y.	
4610 Pine St., New York, N.Y.		Vice President		FGH Company, New York, N.Y.	
4632 Birch St., New York, N.Y.		Secretary		IJK Company, New York, N.Y.	
4654 Cedar St., New York, N.Y.		Assistant		LMN Company, New York, N.Y.	
4676 Elm St., New York, N.Y.		Manager		OPQ Company, New York, N.Y.	
4698 Maple St., New York, N.Y.		Owner		RST Company, New York, N.Y.	
4720 Oak St., New York, N.Y.		Partner		UVW Company, New York, N.Y.	
4742 Pine St., New York, N.Y.		Director		XYZ Company, New York, N.Y.	
4764 Birch St., New York, N.Y.		President		ABC Company, New York, N.Y.	
4786 Cedar St., New York, N.Y.		Vice President		DEF Company, New York, N.Y.	
4808 Elm St., New York, N.Y.		Secretary		GHI Company, New York, N.Y.	
4830 Maple St., New York, N.Y.		Assistant		JKL Company, New York, N.Y.	
4852 Oak St., New York, N.Y.		Manager		MNO Company, New York, N.Y.	
4874 Pine St., New York, N.Y.		Owner		PQR Company, New York, N.Y.	
4896 Birch St., New York, N.Y.		Partner		STU Company, New York, N.Y.	
4918 Cedar St., New York, N.Y.		Director		VWX Company, New York, N.Y.	
4940 Elm St., New York, N.Y.		President		YZA Company, New York, N.Y.	
4962 Maple St., New York, N.Y.		Vice President		BCD Company, New York, N.Y.	
4984 Oak St., New York, N.Y.		Secretary		EFG Company, New York, N.Y.	
5006 Pine St., New York, N.Y.		Assistant		HIJ Company, New York, N.Y.	
5028 Birch St., New York, N.Y.		Manager		KLM Company, New York, N.Y.	
5050 Cedar St., New York, N.Y.		Owner		NOP Company, New York, N.Y.	
5072 Elm St., New York, N.Y.		Partner		QRS Company, New York, N.Y.	
5094 Maple St., New York, N.Y.		Director		TUV Company, New York, N.Y.	
5116 Oak St., New York, N.Y.		President		WXY Company, New York, N.Y.	
5138 Pine St., New York, N.Y.		Vice President		ZAB Company, New York, N.Y.	
5160 Birch St., New York, N.Y.		Secretary		CDE Company, New York, N.Y.	
5182 Cedar St., New York, N.Y.		Assistant		FGH Company, New York, N.Y.	
5204 Elm St., New York, N.Y.		Manager		IJK Company, New York, N.Y.	
5226 Maple St., New York, N.Y.		Owner		LMN Company, New York, N.Y.	
5248 Oak St., New York, N.Y.		Partner			

04935

04942

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1. DECEASED-NAME (Type or Print) <b>HAYWOOD</b>		First Middle Lost		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <b>April 25, 1969</b>		2b. HOUR <b>3:35 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>11-25-1901</b>		6. AGE (In years last birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>N.C. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>PRESTON</b>		First Middle Lost		15. MOTHER'S MAIDEN NAME <b>ALICE</b>		First Middle Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>237-16-7531</b>		17. INFORMANT <b>MRS. LOLA WALKER</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>		EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>4/26/69</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4-4-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE SAWYERS CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>ELIZABETH CITY N.C.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

64043

11-25-1901

1901

1901

*Handwritten signature*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04943

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04936

1. DECEASED-NAME (Type or Print)		First RICHARD		Middle N.		Last BARANOWSKI		2a. DATE KNOWN OF ESTI- DEATH MATEO <input type="checkbox"/> Month Day Year		2b. HOUR April 24, 1969 9:00 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 15, 1921		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR APRIL 24 1969 10:00 AM	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.					
10. CITY OR TOWN OF DEATH Baltimore (Essex)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7746 Eastdale Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Route Salesman-Ice Cream Co.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7746 Eastdale Road			
14. FATHER'S NAME First Middle Last Joseph Baranowski		15. MOTHER'S MAIDEN NAME First Middle Last Beatrice Drozdowski									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW2 213-14-3859		17. INFORMANT Mrs. Anna T. Baranowski		ADDRESS (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. MELVIN B. DAVIS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/25/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69.		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		23e. REGISTRAR'S SIGNATURE Charles Judge		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE					







2  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																								
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
04944					CERTIFICATE OF DEATH					04937														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Powers Avenue</u>					d. STREET ADDRESS <u>Powers Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <u>Rebecca D.</u> Middle <u>Barbour</u> Last					4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1969</u>																			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 13, 1886</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Joseph Eaton</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Rice</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Family records</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4389</u> <u>stroke (left hemisphere)</u> DUE TO <u>thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1966</u> , to <u>April 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1969</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.																								
22a. SIGNATURE <u>Theodore A. de Gaudio, M.D.</u>										22b. DATE SIGNED														
22c. PHYSICIAN'S NAME (Type) <u>Theodore A. de Gaudio, M.D.</u>										22d. ADDRESS <u>4933 Thorskill Rd. Lutherville MD. 21093</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>April 17, 1969</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>									
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>										25a. REC'D BY REGISTRAR DATE <u>APR 18 1969</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									

John Green, Son, Town, Maryland

April 17, 1959

Poplar Grove Cemetery

Cockeysville, Maryland

No

Joseph Cotton

Our Home

Landlord

USA

Female

x

February 13, 1958

April 14,

89

Town, Avenue

Town, Avenue

Cockeysville

Cockeysville

littmore

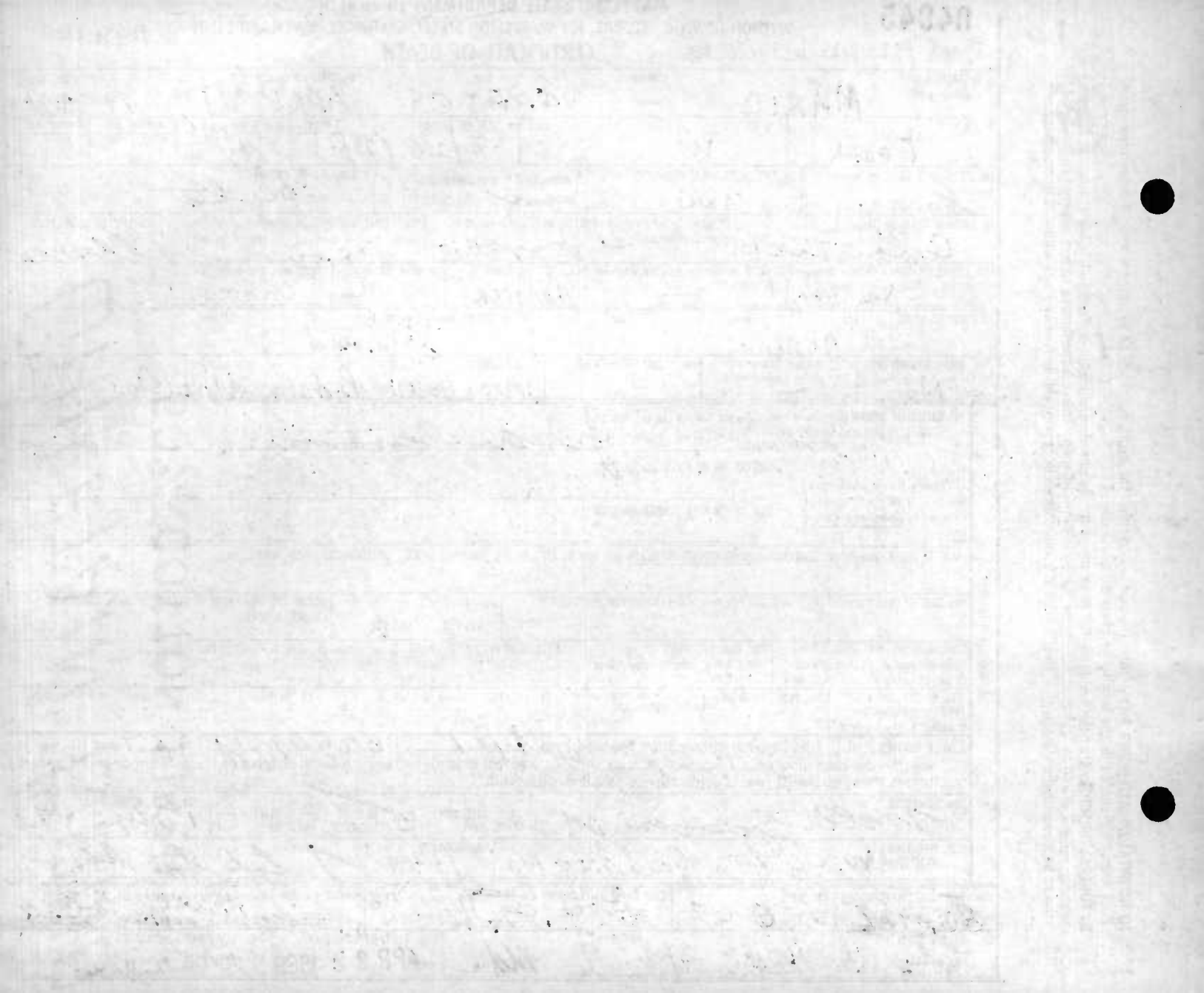
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littmore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
MARIE		-		-		BARTOS		APRIL Month 17 Day 89 Year		8:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		W		2/26/1913		25 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Hungary		USA				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Calumville		St. Joseph's		Nurse		Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
New Jersey				Hanover				Unknown			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Unknown								Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No						Mrs. Helen Padula		Woodstock, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 561X										2 day	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/11/69, 1969, to 4/17/69, 1969 that (I) (we) last saw the deceased alive on 4/16/69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
WILLIAM GOODMAN, M.D.								17 Apr 69			
22d. PHYSICIAN'S NAME (Type)		WILLIAM GOODMAN, M.D.		22e. ADDRESS		1334 Lupton St. N.J.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4-20-69		Gate of Heaven		Hanover, N.J.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harry W. Haight		Lykenville, Md.		APR 22 1969		Charles J. Jones					



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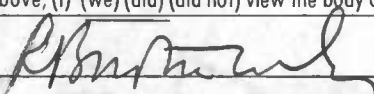
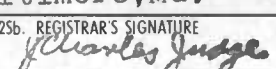
1

04946

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04939

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>David Wade Basch</b>			2a. DATE OF DEATH <b>4</b> Month <b>21</b> Day <b>69</b> Year			2b. HOUR <b>10:09</b> P			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4/18/69</b>		6. AGE (In years last birthday) <b>3 days</b> <del>xxx</del>		IF UNDER 1 YEAR MONTHS <b>3</b> DAYS <b>3</b> HOURS <b>3</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med.Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. CITY <b>Balto.</b>		13c. CITY OR TOWN <b>Overlea</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>339 Elinor Ave.</b>	
14. FATHER'S NAME First <b>Robert Lee</b> Middle <b>Basch</b> Last			15. MOTHER'S MAIDEN NAME First <b>Joanne</b> Middle <b>Faith</b> Last <b>Scagg</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT <b>Robert L. Basch - 339 Elinor Ave.</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema and anoxia</b> <b>7769</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asphyxia neonatorum</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> , 19 <b>69</b> , to <b>4/21</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>4/21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/22/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>				22e. ADDRESS <b>6701 N.Charles St. Balto. Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>4-23-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>John C. Miller Inc</b>				ADDRESS <b>06415 Belair Rd.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1969</b>		25b. REGISTRAR'S SIGNATURE 	

02320

RECEIVED BY [illegible]

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1		04947		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		06423			
Item #11, Film #112 5/14/69 km											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JOSEPH		C.		BATCHELOR		April		Month 27 Day 1969 Year		7A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		W				65 YRS.		MONTHS		OAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wilson, N.C.		U.S.A.				Baltimore				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Cockeysville, Md.		519 Lord Byron Lane				Security Guard					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Cockeysville, Md.		BALTO.		COCKEYSVILLE				319 BYRON ST.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
EMMERSON C.		BATCHELOR						UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT		Address					
		233-34-3864		THOMAS YELVERTON F.H.		WILSON, N.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1621		Branchiogenic Carcinoma						6 mos			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (his hospital) attended the deceased from 1967, to April 25, 1969, that (I) (we) last saw the deceased alive on April 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type)		WILLIAM P. BENSON, JR.		22e. ADDRESS		3502 NCALVERT, BALT, MD.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		4/29/69		Evergreen Mem. Garden		WILSON				N.C.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. J. Tickner & Sons		Balto., Md.		MAY 1 2 1969		MAY 1 2 1969					

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04948

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04940

1. DECEASED-NAME (Type or print)		First Edith	Middle Ida	Lost Baucher	2a. DATE OF DEATH 4 month Pg 69		2b. HOUR 5.05P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 9, 1981		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New Windsor, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co.			
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Balto. Co.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 324 Aigburth Rd. 21204	
14. FATHER'S NAME Charles W.		15. MOTHER'S MAIDEN NAME Mary Ida Ingle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) None		17. INFORMANT Family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from JUL 1964, to APRIL 19, 1969, that (I) (we) last saw the deceased alive on APRIL 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE I. C. Siwinski					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 APR 69		
22d. PHYSICIAN'S NAME (Type) Dr. Thaddeus Siwinski					22e. ADDRESS 206 W. Penna. Ave. Towson, Md. 21204				
23a. BURIAL, CREMATION, OTHER FINAL DISPOSITION (Specify) Burial		23b. DATE April 23, 1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Cemetery Maryland			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland					25a. RECEIVED BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE William Judge		

John Jones

1890-1895

Family records

John

1890

John Jones, born 1890, died 1895  
April 2, 1899  
1895-1899

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04949					04941					
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Mollie Corbett Belton					2a. DATE OF DEATH Month Day Year April 21, 1969					2b. HOUR MIN. 3:45 P.
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5/3/26		6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.				
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 514 N. Calhoun St.	
14. FATHER'S NAME First Middle Last William Corbett			15. MOTHER'S MAIDEN NAME First Middle Last Louise Corbett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 245-62-7363		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular-accident 4330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerosis, hypertension.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/12/68, 19, to April 21, 1969, that (I) (we) lost the deceased alive on April 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dionidis L. Pirovolidis					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-21-69			
22d. PHYSICIAN'S NAME (Type) Dionidis Pirovolidis, M.D.					22e. ADDRESS Spring Grove State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORY Little Giney Grove		23d. LOCATION (City or Town) (County) (State) Sampson Co. N.C.				
24. FUNERAL DIRECTOR Arlington S. Shell					ADDRESS 1727 N. Mount St.		25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...	

04243

NOTES

APR 24 1964

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APR 24 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 2

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
THEODORE ROOSEVELT BENJAMIN						APRIL 18, 1969		3:00A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		NEGRO		10/8/06		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMIN. HOSPITAL		PRINTER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				638 W. FRANKLIN STREET	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CARL - - BENJAMIN			MARY - - CLARK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES		WWII		027 09 0353 CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION BRONCHOPNEUMONIA, BOTH LUNGS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUODENAL ULCER</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>LAENNEC'S CIRRHOSIS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>MAR 13, 1969</u> , to <u>APR 18 1969</u> , that (X) (we) last saw the deceased alive on <u>APR 18 1969</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alfonso A. Lopez</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 19 69		
22d. PHYSICIAN'S NAME (Type) ALPHONSO A. LOPEZ, M.D.					22e. ADDRESS VAH, FT. HOWARD, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4/23/69		BALTIMORE NATIONAL CEMETERY		BALTIMORE		MARYLAND	
24. FUNERAL DIRECTOR ADDRESS Morton & Dyett 1702-31 LAURENS ST.				25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

THEODORE WOODWARD BENJAMIN APRIL 10, 1909 3:00A

MAINTAINED U.S.A. X

MAINTAINED VETERAN'S HOME, HOSPITAL BENJAMIN X 030 W. STANLEY STREET

CARE BENJAMIN - - - CLARK

YES WHITE ONLY 09 0939 CLINICAL RECORD, VAN, PT. HOWARD, MD. DATE MONTHS

LABORATORY'S CLINICAL X

APR 10 1909 APR 10 1909

APR 10 1909 X

BURIAL NATIONAL CEMETERY, BALTIMORE VAN, PT. HOWARD, MD. 1,000-31 JANUARY ST. 1909

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04951  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04943

1. DECEASED-NAME (Type or print) First Middle Last <b>NOLA MARIE BENNETT</b>			2a. DATE OF DEATH Month Day Year <b>4 9 1969</b>		2b. HOUR <b>3:30 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5-7-06</b>		6. AGE (In years lost birthday) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>W. VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOSP. MT WILSON STATE</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>CUMBERLAND</b>	13c. CITY OR TOWN <b>MT WILSON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Rt 1 Box 120 CASHA Valley</b>	
14. FATHER'S NAME First Middle Last <b>LEE HARPER BENNETT</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>NEVA DOVE BENNETT</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. <b>213-48-9567</b>	17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE COR PULMONALE (RESPIRATORY ACIDOSIS)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY EMPHYSEMA, BRONCHIAL ASTHMA.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC BRONCHITIS.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W Newcomer</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>4/9/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/11/1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md.</b>		
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr.</b>		ADDRESS <b>230 Baltimore Ave Cumberland</b>	25a. REC'D BY REGISTRAR <b>APR 11 1969</b>	25b. REGISTRAR'S SIGNATURE <b>W. L. Linder</b>	

San Antonio County

San Antonio County, Texas



San Antonio County, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04944			
04952				CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) <sup>First</sup> JOSEPHINE <sup>Middle</sup> V <sup>Last</sup> BERGER				2a. DATE OF DEATH APRIL <sup>Month</sup> 25, <sup>Day</sup> 1969 <sup>Year</sup>		2b. HOUR <sup>M</sup>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 13, 1907		6. AGE (In years last birthday) 61 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Landsdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 2403 Alma Rd.		14. FATHER'S NAME <sup>First</sup> Andrew <sup>Middle</sup> <sup>Last</sup> Valenzia		15. MOTHER'S MAIDEN NAME <sup>First</sup> Theresa <sup>Middle</sup> <sup>Last</sup> Battaglia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-01-7786		17. INFORMANT Mr John A Berger		Address 5720 Fenwick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Addison Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gingestive heart failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>4</u> <u>4</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from February 19 69 to April 25 19 69, that (I) (we) last saw the deceased alive on April 21 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry Armanas M.D.				22c. DATE SIGNED 4/25/69			
22d. PHYSICIAN'S NAME (Type) HENRY ARMANAS				22e. ADDRESS 1934 Wilkins Ave., Balto Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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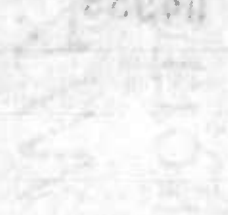
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04953										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04945																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Bessie										Berman										APRIL										Month Day Year										6.26 PM																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
Female										White																				84 YRS										MONTHS DAYS										HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Russia										U.S.A.																				Balto. Co.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Towson, Md.										Dulaney-Towson Nursing Home										HOUSEWIFE										AT HOME																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																			
Maryland										Balto.										BALTIMORE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										6109 Park Heights Ave.																			
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																													
Aaron										SHAPIRO										UNKNOWN																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										NO										MRS. IRVIN GREENBERG, 3737 CLARKS LANE #15																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
403X										IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>										4 days																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Cerebrovascular Hypertensive Vascular Disease</u>										20 years +																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION																																							
																				Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1936</u> , to <u>4-22-69</u> , that (I) (we) lost the deceased alive on <u>3-15-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
																														4-22-69																													
22d. PHYSICIAN'S NAME (Type)										Dr. Meyer Jacobson										22e. ADDRESS																																							
										6821 Reisterstown Rd. Balto. Md. 21215																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										4-24-69										SHAAREI ZION										ROSEDALE, MARYLAND																													
24. FUNERAL DIRECTOR										ADDRESS										25a. DATE OF REGISTRATION										25b. REGISTRAR'S SIGNATURE																													
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD																				APR 25 1969																																							
VR A15 45M - 69																				DATE																																							

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0430

DEPARTMENT OF DEATH



JANUARY

1900

MONSIEUR

WILLIAM

CHURCH

WILLIAM CHURCH

WILLIAM CHURCH

Handwritten notes or signatures in the right margin, including the word "CHURCH" and other illegible text.

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DEPARTMENT OF DEATH

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DEPARTMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JOHN HENRY BEVANS, JR.						April Month 4 Day 1969 <sup>ar</sup>			10:45 <sup>M</sup>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years 75 <sup>st</sup> birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		WHITE		1/13/94		75 <sup>YRS.</sup>			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last year)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		ADMINISTRATION HOSPITAL		SHEET METAL WORKER		ROOFING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		TOWSON				515 E. JOPPA ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN HENRY BEVANS			JULIA BAINES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES		WW-1		215 07 0769 Clinical Rcds, VA Hospital, Fort Howard, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis, cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
OLD C.V.A. AND SPASTIC PARALYSIS (R.)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10</u> , 19 <u>67</u> , to <u>April 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>Erhard J. Bunyor M.D.</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4 4 69</u>		
22d. PHYSICIAN'S NAME (Type) <u>ERHARD J. BUNYOR, M.D.</u>					22e. ADDRESS <u>VA Hospital, Fort Howard, Md.</u>				
23a. BURIAL, CREMATION, BENEFIT (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4/7/69		PARKWOOD CEMETERY		BALTIMORE		MARYLAND	
24. FUNERAL DIRECTOR					25a. REGISTRY DATE		25b. REGISTRAR'S SIGNATURE		
RUCK FUNERAL HOME 5305 Harford Road Baltimore, Md.					APR 7 1969		<u>Charles Judge</u>		

04554

CHRONIC DISEASE

NAME: [illegible] ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DATE: [illegible] TIME: [illegible]

REASON FOR VISIT: [illegible]

PHYSICIAN: [illegible]

TESTS: [illegible]

DIAGNOSIS: [illegible]

TREATMENT: [illegible]

PROGNOSIS: [illegible]

REMARKS: [illegible]

DATE: [illegible]

BY: [illegible]

REMARKS: [illegible]

DATE: [illegible]

BY: [illegible]

REMARKS: [illegible]

DATE: [illegible]

BY: [illegible]

REMARKS: [illegible]

DATE: [illegible]

APR 7 1952  
PARKWOOD DISPENSARY  
1000 UNIVERSITY BLVD  
ANN ARBOR, MI 48106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>04955</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div>										<div>04947</div>																	
1. DECEASED-NAME (Type or print)			First ANNA			Middle BIJAN			Last			2a. DATE OF DEATH Month 4			Day 10			Year 69			2b. HOUR 8:57						
3. SEX F			4. RACE CAU			5. DATE OF BIRTH 9-26-94/93			6. AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN.						
7a. BIRTHPLACE (State or foreign country) UKRAINE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.																		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY																		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1116 Chatterleight Circle															
14. FATHER'S NAME First John			Middle Behanos			Last			15. MOTHER'S MAIDEN NAME First Katherine			Middle Zirra			Last												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —			17. INFORMANT Stephen Ryan 1116 Chatterleight Circle																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE ANEMIA - G. I. BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LARGE GASTRIC ULCER - LESSER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CURVATURE - CONGESTIVE HEART FAILURE</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																		
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>4/3</u> , 19 <u>69</u> , to <u>4/10</u> , 19 <u>69</u> , that <del>he</del> (we) last saw the deceased alive on <u>4/10</u> , 19 <u>69</u> , and that in <del>the</del> (my) (our) apinial death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <i>Malcolm C. Sheppard</i>			DEGREE ATTENDING PHYS.						MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS.			22c. DATE SIGNED 4-10-69												
22d. PHYSICIAN'S NAME (Type) DR. MALCOLM C. SHEPPARD			22e. ADDRESS 6701 N. CHARLES ST., BALTO., MD.																								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4/14/69			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery						23d. LOCATION (City or Town) (County) (State) Baltimore Md.															
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.												ADDRESS 1501 E. Fort Avenue						25a. REC'D BY REGISTRAR DATE APR 15 1969				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

04025

DEPARTMENT OF HEALTH

DIVISION OF HEALTH, STATE OF NEW YORK, ALBANY, NEW YORK

6118

FILE

FILE

APR 18 1968



7  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10  
03  
1

2

04956		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		04948							
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month 4 Day 25 Year 69		2b. HOUR 12:45 P.M.					
Richard			John Blair										
3. SEX male		4. RACE white		5. DATE OF BIRTH Aug. 5, 1912		6. AGE (In years lost birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Industry							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Sparrows Pt.		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 7122 River Drive Road					
14. FATHER'S NAME Richard J. Blair			First	Middle	Last	15. MOTHER'S MAIDEN NAME Emily Kahl			First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 217-01-8851			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-renal failure - 21 hours days 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A S H D with congestive heart failure days DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from March 11, 1968, to April 25, 1969, that (I) (we) lost saw the deceased alive on April 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Albert M. Gutierrez, M.D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-25-69				
22d. PHYSICIAN'S NAME (Type) ALBERTO M. GUTIERREZ, M.D.					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City or Town) Parkville, Balto. Co., Md.		(County)		(State)			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					25a. REC'D BY REGISTRAR DA APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

04550

Industry

Imported

Aluminum & Magnesium

Grand 11/28/60 Moreland Nat. Bank Knoxville, Tenn. Co., Tenn.

H. S. Jenkins & Sons Co. 1905 York Rd. APR 2 1962

Belle, Ind. Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

04957		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04949	
Items 1&15 taken from birth cert. CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last Bloomfield, Baby Andrew Boy Kenneth			2a. DATE OF DEATH 4 Month 26 Day 69 Year		2b. HOUR 2:55 M
3. SEX Male	4. RACE Caucasion		5. DATE OF BIRTH 4/26/69		6. AGE (In years last birthday) YRS. MONTHS DAYS 5 5 30
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med.Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Joppa	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 419 Acadia Road	
14. FATHER'S NAME First Middle Last Capt. Kenneth Bloomfield			15. MOTHER'S MAIDEN NAME First Middle Last Rose Miriam Chilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Capt. Kenneth Bloomfield, 419 Acadia Rd. Joppa, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7769 IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 26, 1969, to April 26, 1969, that (I) (we) lost saw the deceased alive on April 26, 1969, and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John E. Adams				22c. DATE SIGNED 4/27/69	
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.				22e. ADDRESS 6701 North Charles St. Balto. Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 2, 1969		23c. NAME OF CEMETERY OR CREMATORY West Point Cemetery	
23d. LOCATION (City or Town) (County) (State) West Point, New York					
24. FUNERAL DIRECTOR Harry H. Witzke, 4112 Columbia Pike, Ellicott City, Md. 21043		25a. REC'D BY REGISTRAR DATE MAY 2 1969		25b. REGISTRAR'S SIGNATURE John E. Adams	

7220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
MAGDALENA			TERESA		BOND		APRIL		Month 28, Day 1969		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7b. HOUR		
FEMALE		WHITE		DECEMBER 15, 1882			86 YRS.		1:45A		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.AA.				BALTIMORE, Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			Housewife			at home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			Baltimore		Perry Hall				9912 FORGE PK. RD. #21128		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Hartman			unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
					21128						
					Anthony Miller, son, 9912 Forge Pk. Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial Infarction											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Arteriosclerotic Vascular Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from MARCH 1, 1969, to April 28, 1969, that (X) (we) last saw the deceased alive on APRIL 28, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Villafania						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 28, 1969			
22d. PHYSICIAN'S NAME (Type) A. Villafania, M.D.						22e. ADDRESS 7620 York Road Towson, Maryland #21204					
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE 5/1/69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane						25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

04332



FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 23a thru 24  
film G412 5/16/69 jcp

04959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04951

1. DECEASED-NAME (Type or Print) <b>KIM TRACY BOWERS</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>4-2 1969</b>			2b. HOUR OF DEATH <b>3:04 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>7-19-62</b>		6. AGE (In years last birthday) <b>6</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>			
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Balt. County</b>				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street or address) <b>Belt County General Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>				13b. COUNTY <b>Belt</b>				13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4015 Rowen Rd.</b>	
14. FATHER'S NAME <b>Robert</b>						15. MOTHER'S MAIDEN NAME <b>Claine Hampin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, if unknown) <b>No</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Mr Robert Bowers</b>				ADDRESS <b>4015 Rowen Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Death the result of being hit by a truck - resulting in compound</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ambushed fracture of left skull</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>814.7</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day Year <b>April 2 Prior to 3:04 PM 19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>while crossing street hit by truck</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>on street</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rowen Rd. Balt County MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Robert B. Taylor MD</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>Robert Bruce Taylor</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>4/4/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chizuk Amuno (Arlington)</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros., 6010 Reisterstown Road</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

BOSTON FIELD OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04960

04952

1. DECEASED-NAME (Type or print) <b>SOPHIE L. BOWERS</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>69</b>			2b. HOUR <b>6:10 P M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 5, 1890</b>		6. AGE (In years lost birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>ST. JOSEPH, MISSOURI</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7928 DUNHILL VILLAGE CIRCLE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7928 DUNHILL VILLAGE CIRCLE</b>	
14. FATHER'S NAME First Middle Last <b>SOLOMON SACHS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>BESSIE SEGALL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-38-0536A</b>		17. INFORMANT Address <b>MR. STANLEY I. BOWERS, 7114 MINNA ROAD #7</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>3 YRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>67</b> , to <b>April</b> , 19 <b>69</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 12</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <b>Leon G. Sheer, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/22/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>LEON G. SHEER, M.D.</b>				22e. ADDRESS <b>6715 PARK HEIGHTS, BALTO. MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4-24-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				25a. REC'D BY REGISTRAR DATE <b>APR 25 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Emily Jane Brandenburg						April 15, 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female		White		Feb. 20, 1893			76 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U. S. A.					Balto. Co. Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			47 Overbrook Rd.			School Teacher			Balto. City
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Catonsville			47 Overbrook Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Stephen A. Brandenburg			Margaret Crst						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
no			214-38-2790A		Catonsville, Md. Miss. Ethel Brandenburg 47 Overbrook Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1533 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Resection of sigmoid 5-years ago due</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>to adenocarcinoma</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 22, to 4/15, 19 69, that (I) (we) last saw the deceased alive on 4/15, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		DAMIAN PALAGIA			3300 Frederick Ave		4/15/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		April 19, 1969		Woodlawn Cem.			Woodlawn, Balto. Md.		
24. FUNERAL DIRECTOR				ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
G. Truman Schwab 5151 Balto. Md. 21229				National Pike			APR 21 1969		ml. - [Signature]





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04962

CERTIFICATE OF DEATH

04954

1. DECEASED-NAME (Type or print) <b>Julius E Brandt Sr</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>69</b>			2b. HOUR <b>M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 18, 1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Forest Haven Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Contractor, Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balt.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1727 Carswell St</b>			
14. FATHER'S NAME First <b>Ernest</b> Middle <b>P</b> Last <b>Brandt</b>			15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>B</b> Last <b>?</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-26-5265</b>		17. INFORMANT Address <b>Julius Brandt Jr 10410 Greentop Rd</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4124</b> <b>BRUISED SCALP - CRANIAL - CONTUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OLDEN &amp; RUMP, FALLING AND</b> DUE TO, OR AS A CONSEQUENCE OF <b>APURC CIRCULATORY COLLAPSE</b> (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>69</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 19 <b>68</b> , to <b>4/12</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John H. Shaw M.D.</b>				DEGREE <b></b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/14/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b>				22e. ADDRESS <b>5800 Edmonson Ave Baltimore Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR DATE <b>APR 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

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<div>04963</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04955</div>											
1. DECEASED-NAME (Type or print) <b>Reubin</b>			First Middle Last <b>---</b> <b>Braudes</b>			2a. DATE OF DEATH <b>4</b> Month <b>4</b> Day <b>69</b> Year			2b. HOUR <b>10:50 A.M.</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>12/29/97</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CONTRACTOR PLUMBING &amp; HEATING</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3615 Courtleigh Drive</b>		
14. FATHER'S NAME First Middle Last <b>ABRAHAM</b> <b>BRAUDES</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>RACHAEL</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) <b>YES</b> (If yes give war or dates of service) <b>W.W. I M.C.</b>			16b. SOCIAL SECURITY NO. <b>216-32-6560</b>			17. INFORMANT <b>MRS. PEARL BRAUDES, 3615 COURTLEIGH DRIVE RANDALLSTOWN, MD. 21133</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>519.2 Infective. Short failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COR PULMONALE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>WEEKS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> , 19 <b>69</b> , to <b>4-4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-4</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Angelita A. Topacio</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>4-4-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>ANGELIT A. TOPACIO</b>						22e. ADDRESS <b>BL 2A1 RANDALLSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>4-6-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>			23d. LOCATION (City or Town) (County) (State) <b>ROSEDALE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR <b>APR 9 1969</b>			25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>		

04363

EXHIBIT OF 04363

UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
Anna M. Brauer								April Month 8 Day 69 Year		7A. M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
F.M.		White		April 6, 77		92 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore		U.S.A.				Baltimore County				Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Owings Mills Md.		9922 Reisterstown Rd.		Buyer for Stewarts		Millery				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Baltimore		Owings Mills		YES <input type="checkbox"/> NO <input type="checkbox"/>		9922 Reisterstown Rd.		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First
Henry Brauer								Elisabeth Peetz		Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
NO		220-44-7111		Miss Helen Knoer Rt. 5 Box 325		21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										5 days
IMMEDIATE CAUSE (a) Terminal Pneumonia										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Arteriosclerotic C.V. Disease										years
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1969, to April 8, 1969, that (I) (we) lost saw the deceased alive on April 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED
Martin E. Strobel				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		4-8-69
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Martin E. Strobel, M.D.		59 Hanover Rd. Reisterstown Md.								21136
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		April 30, 69		Loudon Park Cem.		Baltimore Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Loring Byers		8728 Liberty Rd. Randallstown		APR 10 1969		Richard Judge				

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>Mitchell</b>			Middle <b>Wayne</b>			Last <b>BRITTINGHAM</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>5/20/64</b>			20. DATE OF DEATH Month <b>4</b> Day <b>21</b> Year <b>69</b>		
6. AGE (In years last birthday)			7. BIRTHPLACE (State or foreign country)			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>			13c. CITY OR TOWN <b>Delmar</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <b>Chester</b>			Middle <b>Wayne</b>			Last <b>Brittingham</b>			15. MOTHER'S MAIDEN NAME First <b>Linda</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>no</b>			16b. SOCIAL SECURITY NO. <b>----</b>			17. INFORMANT <b>Rosewood Records, Owings Mills, Md. 21117</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>Pneumonia</b> <b>4862</b> IMMEDIATE CAUSE (a) <b>4862</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Microcephaly with spasticity. Right hemiplegia and right facial palsy.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/17/1969</b> , to <b>4/21/1969</b> , that (I) (we) last saw the deceased alive on <b>4/21/1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Orlando C. Ramos, M.D.</i>										22c. DATE SIGNED <b>4/21/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Orlando C. Ramos, M.D.</b>						22e. ADDRESS <b>Rosewood State Hospital, Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>4/24/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Bonny Can</b>			23d. LOCATION (City or Town) (County) (State) <b>Killbuck Manor Md.</b>		
24. FUNERAL DIRECTOR <i>M. S. Manuel, Delmar, Del.</i>						25a. REC'D BY REGISTRAR DATE <b>APR 23 1969</b>			25b. REGISTRAR'S SIGNATURE <i>Chas. A. Judge</i>		

MEDICAL CERTIFICATION

04862

Name		Address		City	
John Doe		123 Main St		New York	
Age		Sex		Marital Status	
35		Male		Single	
Occupation		Education		Religion	
Teacher		High School		Catholic	
Income		Assets		Liabilities	
\$10,000		\$5,000		\$2,000	
References		Character		Remarks	
Good		Excellent		None	

Approved by: \_\_\_\_\_  
Date: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-68  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04966									
CERTIFICATE OF DEATH									
04958									
1. DECEASED-NAME (Type or print)			First James Middle Stuart Last Brown			2a. DATE OF DEATH		2b. HOUR	
JAMES			STUART BROWN			Month Day Year		139A M	
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (In years lost birthday)	
M MALE			W			8/8/1914		54 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Balto., Md.			U.S.A.					Baltimore Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			8201 Pleasant Plains Rd.			Bar Tender		Amble Inn	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Balto.			Towson		8201 Pleasant Plains Rd	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Harry Brown			Frances Mansfield						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
Yes WWII			213-01-6354			Mrs. Helen D. Brown		(Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENEC'S CIRRHOSIS								10 YEARS	
5710 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CARCINOMA OF PHARYNX									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1968, to APRIL 1, 1969, that (I) (we) last saw the deceased alive on MARCH 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Samuel O'Mansky MD									April 1, 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
SAMUEL O'MANSKY					8523 LOCKRAVEN BLVD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/4/1969		Baltimore National		Baltimore Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H.W. Jenkins & Sons Co. 4902 York Rd. Balto., Md.					APR 2 1969		Charles Judge		

04360

1/1/1900

George - Smith

Overland

Business

U.S.

2001 Leavenworth Station, Leavenworth, Kansas

2001 Leavenworth Station, Leavenworth, Kansas

2001 Leavenworth Station, Leavenworth, Kansas

2001 Leavenworth Station, Leavenworth, Kansas



W. J. ...  
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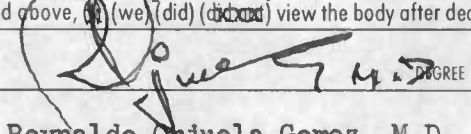
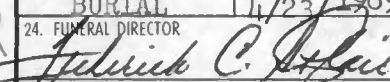
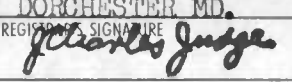
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TO HOSPITAL OR... TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
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04967

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04959

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
WIONA			BALLARD		BRYAN	APRIL 19, 1969			8:10 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		NEGRO		FEBRUARY 4, 1924		45 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON 21204			ST. JOSEPH HOSPITAL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			V. Borch. #21613		CAMBRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		805 FAIRMOUNT AVENUE		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
ANDREW					MADDOX	BEATRICE					BALLARD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
NO						ROGER BRYAN, CAMBRIDGE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal carcinomatosis, Primary in pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from April 5, 1969, to April 19, 1969, that (X) (we) last saw the deceased alive on April 19, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 						22c. DATE SIGNED APRIL 19, 1969					
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.						22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			4/23/1969		WAUGH CEMETERY		CAMBRIDGE, DORCHESTER MD.				
24. FUNERAL DIRECTOR 						ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE 	

04267

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>04968</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 13 Film 412 5/1/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>04960</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Mary Catherine Buccheri						Month 4 Day 23 Year 69			5:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Female		Cau.		9-13-22			46 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Boston, Mass.		U.S.A.					Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			St. Joseph's Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		106 Ardoon Rd. 7620 York Road / 21204	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Peter Laurino			Josephine Sardella								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			?			Joseph S. Buccheri					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinomatosis, primary in breast</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from <u>April 21, 1969</u> , to <u>April 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
Dr. R. Orquela Gomez					7620 York Rd. Towson 4, Md.						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		4-26-1969		Dulaney Valley Memorial			Cockeysville, Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson 1050 York Road 21204					APR 25 1969			Charles Judge			

2024

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1000-1000-1000 .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-59

04969										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04961																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										Hour Min																													
EDGAR MONROE BULL										April 9 1969										2:20 M																													
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH Jan. 23, 1921										6. AGE (In years last birthday) 48 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md.																			
10. CITY OR TOWN OF DEATH FORT HOWARD										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration Hospital										12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) CLERK										12b. KIND OF BUSINESS OR INDUSTRY SOC. SECURITY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY CARROLL										13c. CITY OR TOWN SYKESVILLE										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 149 Carter Road									
14. FATHER'S NAME First Middle Last THOMAS E. BULL										15. MOTHER'S MAIDEN NAME First Middle Last ODA SINDALL																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES										16b. SOCIAL SECURITY NO. WW-11										17. INFORMANT Clinical Rcds, VA Hospital, Fort Howard, Md.										Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY THROMBOSIS, RECENT DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHOPNEUMONIA, RECENT																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MULTIPLE SCLEROSIS, CLINICAL, OLD.																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (a) (this hospital) attended the deceased from April 8, 1969, to April 9, 1969, that (b) (we) last saw the deceased alive on April 9, 1969, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Erhard I. Bunyor M.D.										22c. DATE SIGNED 4/9/69										22d. PHYSICIAN'S NAME (Type) ERHARD I. BUNYOR, M.D.										22e. ADDRESS VA Hospital, Fort Howard, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4-12-69										23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Cemetery										23d. LOCATION (City or Town) (County) (State) Hereford Carroll Maryland																			
24. FUNERAL DIRECTOR HAIGHT FUNERAL HOME										ADDRESS ELDERSBURG, MD.										25a. REC'D BY REGISTRAR DATE APR 14 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																			

FOR DEATH: JAILBROTH: 2704

THOMAS, GEORGE ALFRED, 1894-1960

### NEEDS ASSESSMENT

UNITED STATES DEPARTMENT OF AGRICULTURE

221

EDWARD E. BARKER, M.D.,  
VA Hospital, Fort Howard, Md.

DAUGHTER: MRS. J. H. HARRIS, JR., 1000 14th St. N.W., Wash., D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04970

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04962

1. DECEASED-NAME (Type or print) <b>Harvey Richard Burgoon</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1969</b>			2b. HOUR <b>1:12</b> P.M.			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 8, 1898</b>		6. AGE (In years lost birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2716 Berwick Ave. # 21234</b>	
14. FATHER'S NAME First <b>Harvey</b> Middle <b>m</b> Last <b>Burgoon</b>			15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>m</b> Last <b>Frock</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>216-09-0533A</b>		17. INFORMANT <b>Mrs Lorene M Burgoon</b>		Address <b>Same</b>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>April 2</b> , 19 <b>69</b> , to <b>April 2</b> , 19 <b>69</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>April 2</b> , 19 <b>69</b> , and that in <del>(x)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(x)</del> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Beatriz Dizon</i> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>April 2, 1969</b>					
22d. PHYSICIAN'S NAME (Type) <b>Beatriz Dizon, M.D.</b>				22e. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/5/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morland Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 3 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

04570

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

DEPARTMENT OF THE ARMY

1950

TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04971		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04963		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print) <b>LAST</b> <b>BURK</b>		Middle <b>Carl</b>		<b>FIRST</b> <b>ANDREW</b>		20. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1969</b>		2b. HOUR <b>7:30 a.m.</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 21, 1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON 21204</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Gardner-retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>(State)</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>909 Radcliffe Road-21204</b>		
14. FATHER'S NAME First <b>Andrew</b> Middle <b>Carl</b> Last <b>Burk</b>				15. MOTHER'S MAIDEN NAME First <b>Catherine</b> Middle <b>Trapp</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <b>No</b> (Unknown) <b>None</b>		16b. SOCIAL SECURITY NO. <b>217-09-0351A</b>		17. INFORMANT <b>Family records</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into lungs</b> <b>450 X</b> DUE TO, OR AS A CONSEQUENCE OF <b>pulmonary embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>March 6, 1969</b> , to <b>April 5, 1969</b> , that <del>he</del> (we) lost the deceased alive on <b>April 5, 1969</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (do not) view the body after death.								
22b. SIGNATURE <b>Samuel C. H. Lee, M.D.</b>		22c. DATE SIGNED <b>April 5, 1969</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) <b>Samuel C. H. Lee, M.D.</b>		22e. ADDRESS <b>7620 York Road, Towson 4, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 8, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Blenheim, Balto. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>John Burns Sons</b>		ADDRESS <b>Towson</b>		25a. REC'D BY REGISTRAR <b>APR 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

01301

Card

AUGUST 21 1907

RECEIVED

State

Commonwealth

Town

(Catherine Tapp)

Family records

Andrew Ford

to

Memorandum of the  
of the

01301

March 6

April 2, 1908

7000 Park Road, Town of

April 2, 1908

Charles

1908

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04972

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04964

1. DECEASED-NAME (Type or print)		First <b>GEORGE</b>	Middle <b>A.</b>	Last <b>BURLEY</b>	2a. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>69</b>		2b. HOUR <b>4:00AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>5/8/98</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.						
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL PLANT</b>						
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? <b>X</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>2807 BRIGHTON STREET</b>						
14. FATHER'S NAME First <b>JOHN</b> Middle <b>BURLEY</b> Last <b>BURLEY</b>		15. MOTHER'S MAIDEN NAME First <b>SARAH</b> Middle <b>QUEEN</b> Last <b>QUEEN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>YES</b> (If yes give year or dates of service) <b>WW I</b>					16b. SOCIAL SECURITY NO. <b>218 07 18 64</b>		17. INFORMANT <b>VAH FORT HOWARD, MD. CLINICAL RECORDS</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1950</b> <b>INTRA ABDOMINAL CANCER WITH METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1950</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1950</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GENERAL DEBILITY</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>X</b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>4/25/69</b> , 19____, to <b>4/29/69</b> , 19____, that <b>X</b> (we) last saw the deceased alive on <b>4/29/69</b> , 19____, and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (I) (we) (did) <b>(did not)</b> view the body after death.												
22b. SIGNATURE <b>George C. McElpatrick MD</b>		22c. DATE SIGNED <b>4/29/69</b>			22d. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>							
22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										
23b. DATE <b>5-5-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>							
24. FUNERAL DIRECTOR <b>V.R. Bailey</b>		25a. ADDRESS <b>KELSON FUNERAL HOME</b>			25b. DATE BY REGISTRATION <b>MAY 2 1969</b>		25c. OFFICIAL SIGNATURE <b>[Signature]</b>					
25d. ADDRESS <b>1348 N. Calhoun St. Baltimore, Md.</b>												

04378

WILLIAM  
HALL  
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HALLINGBURY COUNTY

PORT HOWARD  
WILLIAM  
218 OF 18 OF VAN TON HOWARD, MD. CLIMBER RECORD  
WILLIAM  
218 OF 18 OF VAN TON HOWARD, MD. CLIMBER RECORD

GENERAL DELIVERY

18

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GEORGE O. IN BIRMINGHAM, N. D. VAN TON HOWARD, WILLIAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04973									
04965									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR p.m.
Blanche			V. Burrs			April 1, 1969			2:20 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
female		white		March 13, 1913		56		YEARS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			SPRING GROVE STATE HOSP.			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Balto.		White Marsh				Box 52
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
George Hoffman			Ginny						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			220-30-5326		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF <u>advanced arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old CVA &amp; R. Hemiplegia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <u>March 26, 1969</u> , to <u>April 1, 1969</u> , that <del>(X)</del> (we) last saw the deceased alive on <u>April 1, 1969</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.									
22b. SIGNATURE <u>Miguel Heredia, M.D.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-1-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Miguel Heredia, M.D.</u>					22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Buried</u>		<u>4/5/69</u>		<u>Holly Hill Cemetery</u>		<u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Joseph Funeral Home</u>					ADDRESS <u>740 Delair Rd. Baltimore 36, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4-64)  
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
04974									
04966									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Elizabeth			D. Cadell			April 9, 1969			10:30 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		White		Nov. 10, 1891		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Catonsville		Md. U.S.A.				Baltimore County, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville, Md.		118 Smithwood Ave.		Housewife		---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Baltimore		Catons-				118 Smithwood Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frederick R. Diehlmann			Katherine Bechman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			220-46-9363		W. E. Cadell -203 Hilton Ave. -21228				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF <u>with chronic failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>69</u> , to <u>4-9</u> , 19 <u>69</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>4-3-</u> 19 <u>69</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.									
22b. SIGNATURE <u>John A. Nesbitt, Jr.</u>				22c. DATE SIGNED <u>4-10-69</u>					
22d. PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D.				22e. ADDRESS 1009 Frederick Road, 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/11/69		Cem Salem Lutheran Church		Catonsville, Balto., Md.			
24. FUNERAL DIRECTOR <u>Sterling Funeral Estate</u>				ADDRESS <u>736 Edmondson Ave. Catonsville, Md. 21228</u>		25a. RECEIVED BY REGISTRAR <u>APR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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04975		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04967			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First George	Middle E.	Last Caltrider	2a. DATE OF DEATH April Month 10 Day 69 Year		2b. HOUR 6 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 1, 1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto. City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Glyndon		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2 Chatsworth Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Iron Fitter		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Glyndon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 Chatsworth Ave.	
14. FATHER'S NAME John			First Middle Last	15. MOTHER'S MAIDEN NAME Mary Ford			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-01-5079		17. INFORMANT Mrs. Edna M. Caltrider			Address Glyndon, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.V. and D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Hemorrhage</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>10 years</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u> <u>1 yr</u> <u>10 years</u>			
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <input checked="" type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-69</u> to <u>4-10-69</u> , that (I) <u>and</u> saw the deceased alive on <u>4-7-69</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>did</u> (did not) view the body after death.									
22b. SIGNATURE <u>James B. Saffell</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>4-10-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>James B. Saffell</u>		22e. ADDRESS <u>Reisterstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 14, 69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u>				ADDRESS <u>Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

04337

CHIEF OF POLICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04968	
04976										CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) <b>SUSAN</b> <b>Campbell, Susan</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>69</b>			2b. HOUR <b>11:50 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>8-2-1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>11</b>		IF UNDER 24 HRS. HOURS <b>11</b> MIN. <b>50</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Stella Maris Hospice</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <b>Balto.</b>		13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>34 York Ct.</b>			
14. FATHER'S NAME First <b>Thomas</b> Middle <b>Campbell</b> Last <b>Campbell</b>			15. MOTHER'S MAIDEN NAME First <b>Virginia</b> Middle <b>Dunn</b> Last <b>Dunn</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <b>220-30-0034</b>		17. INFORMANT <b>T.D. CAMPBELL STELLA MARIS HOSPICE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Delirium</b> <b>153.8</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF <b>intra-abdominal metastases</b> (c) <b>Diabetes mellitus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY</b> , 19 <b>68</b> , to <b>APR</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>APR. 7</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. David Nagel</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/8/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>J. DAVID NAGEL</b>					22e. ADDRESS <b>STELLA MARIS HOSPICE</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/10/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD.</b>				
24. FUNERAL DIRECTOR <b>H. W. NEARS &amp; SON</b>					ADDRESS <b>805 N. CALVERT ST</b>		25a. RECEIVED BY REGISTRAR <b>APR 11 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

04977

04969

1. DECEASED-NAME (Type or print)		First <b>LOUIS</b>	Middle <b>DEWEY</b>	Lost <b>CAMPEGGI</b>	2a. DATE OF DEATH <b>APRIL</b> Month <b>20</b> Day <b>1969</b> Year		2b. HOUR <b>10:30AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 6, 1898</b>		6. AGE (In years lost birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS OAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>Fort Howard</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Veterans Administration</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Barber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5806 Harford Road</b>
14. FATHER'S NAME <b>Frank</b>		First <b>Frank</b>	Middle <b>Campeggi Sr.</b>	15. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		First <b>Elizabeth</b>		Lost <b>Otis</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b>		(If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>212 14 2730</b>		17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKNOWN</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 18, 1969</b> to <b>April 20, 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 20, 1969</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE <b>Elsa M. Goris</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/20/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>ELSA M. GORIS, M.D.</b>					22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 24, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>					ADDRESS <b>5305 Harford Road</b>		25a. REC'D BY REGISTRAR <b>APR 21 1969</b>	
					DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04978		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04970		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First GAETANA	Middle NMN	Last CARLOTTA	2a. DATE OF DEATH APRIL Month 16 Day 69 Year		2b. HOUR 1:40 P.M.
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH May 20, 1896 1895.		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2912 Grindon Avenue
14. FATHER'S NAME First Middle Last Joseph Determini			15. MOTHER'S MAIDEN NAME First Middle Last Mary Determini					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-40-5885		17. INFORMANT Mrs. Mary McClure			Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1579 DUE TO, OR AS A CONSEQUENCE OF METASTATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF PANCREATIC PRIMARY CARCINOMA (c) MO TO A YR APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH L 8 L 1MO								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 4-10-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY CA LIVER METASTATIC			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 4-3, 19 69 to 4-16, 19 69, that (X) (we) last saw the deceased alive on APRIL 16 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard C. Smith MD				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-16-69		
22d. PHYSICIAN'S NAME (Type) DR. RICHARD SMITH MD				22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/21/69.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04979 CERTIFICATE OF DEATH 04971									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Joseph			D. Catalano			4 17 69			7:30 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		Cau.		8-12-12			56 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Baltimore							Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Baltimore			St. Joseph's Hospital			Machine Operator			Tool
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Sparks			26 Belclare Circle	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Dominic Catalano			Antonia Vitale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes WW 2			216-09-7178		Mrs. Alicia Catalano 26 Belclare Circle, Sparks, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Sepsis</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>April 16</u> , 19 <u>69</u> , to <u>April 17</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Samuel C.H. Lee</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>April 18, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Samuel C.H. Lee</u>					22e. ADDRESS <u>7620 York Road, Towson, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4-21-1969		Sacred Heart Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson 1050 York Rd. 21204					APR 21 1969		<u>Charles Judge</u>		

04373

To:

Y. 2 2 - 0 - 7 7

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04980									
04972									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Bertie Henderson Chaney						April Month 24 Day 69 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		Feb. 11, 1886		83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Baltimore		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Ruxton		2006 Indian Head Rd.		Retired Homemaker		own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Ruxton				2006 Indian Head Rd.	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last
Gaither			W. Henderson			Allie			Burgess
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		213-40-8442		Mrs. Wm. H. Marshall, Jr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1579 DUE TO, OR AS A CONSEQUENCE OF								3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma pancreas								1-17-69	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from January 6, 1969, to April 24, 1969, that (I) (we) lost the deceased alive on April 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald O. Wood					22c. DATE SIGNED 4-25-69				
22d. PHYSICIAN'S NAME (Type) Donald O. Wood					22e. ADDRESS York Rd. & Greenmeadow Dr.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-26-69		Smithville		Dunkirk Md.			
24. FUNERAL DIRECTOR H. W. Jenkins Sons Co.				4905 York Rd. Balto. 21212, Md.		25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE	

04220

RECEIVED

04220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04981					04973					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
IDA E. CLARK					April 26, 1969		3:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		April 26, 1989		80 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Baltimore		U S A				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Shangralla N/H			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 240-A Long Point	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Andrew F. Kroupa			Theresa Schinck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		220-30-2404 Mrs. C. Wilmer Lurz - Daughter Same as #					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary Emboli										
412.3 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-12-1966, to 4-26-1969, that (I) (we) last saw the deceased alive on 4-26-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cesar Valle Cervero					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO					22e. ADDRESS 8629 Liberty Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/29/69		Holy Redeemer Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Singleton Funeral Home Glen Burnie, Maryland				APR 29 1969		Charles Judge				

04381

STATE OF OHIO

MAINTAIN THE RECORDS OF THE STATE OF OHIO

APRIL 25, 1952

CLARK

E.

for

60

APRIL 25, 1952

with

Form

self/more

self/more

Box 1

Household

Personal

Personal

Box 2 - 1000

Personal

Personal

Personal

Personal

Personal

Personal

Box 3 - 1000 - 1000

Box 3

Box 3

Box 4 - 1000

Box 4 - 1000

Box 4

Box 4

Box 5

Box 5 - 1000

Box 5 - 1000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04982

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04974

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR			
RAYMOND N. CLARKE, SR.						Month Day Year			4 19 1969			4:am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			
Male		White		April 7, 1912		57 YRS.						Month Day Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					2d. HOUR				
Baltimore, Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Balto.					4:am				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk				2000 LarkHall Rd.				Route Salesman				Milk Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.				Balto.				Dundalk				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.			
Harvey Clarke				Gerturde F. Disney				No				213 10 7368			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4124</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Raymond Clarke, Jr. 912 "B" Ashbridge Dr.				Balto., Md. 21221											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> PARTIAL							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 4/19/69							
Edward F. Wilson, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				4/25/69				Parkwood Cemetery				Baltimore Co., Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Brudzinski Funeral Home 1407 Eastern Ave.				APR 25 1969				Charles Judge							

HEALTH DEPT  
FOU STATE

04082

MINISTRY OF HEALTH  
OFFICE OF THE DIRECTOR  
GENERAL SECRETARIAT

DATE: 1954

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 1969  
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
049883					04975				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last <b>Bennett Bussey Cockey</b>					Month Day Year <b>4/ 4/ 69</b>				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		2b. HOUR
male		white		May 21, 1901			67 YRS.		3:50 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			lawyer		General Law	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER
Md.			Balto.		Cockeysville				Beaver Dam Road
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Joshua F. Cockey III					Anna Bussey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes, no, or unknown			218-40-8036		Records & SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, lung abscess.</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1968</u> , to <u>April 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. SHEETS, MD</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>April 4, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>R. SHEETS, MD</u>					22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		April 7, 1969		Shenwood Church Cemetery			Cockeysville, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
John Burns' Sons, Towson, Maryland					APR 10 1969		<u>Charles Judge</u>		

1952

STATE OF TEXAS

County of ...

...

John ...  
April 7, 1952  
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04984		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04976	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
Nicholas			Joseph	Colantonio	4 Month 21 Day 69 Year		2b. HOUR 9am M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years less birthday) YRS.	
Male		White		8-9-10		138	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Penna		U.S.				Baltimore County Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last working year, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown		Balt. Co. Gen. Hospital		BRICKLAYER		BUILDING	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Baltimore				21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
Frank PAUL		MARIA Amabile		NO ***		217 07 6863	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4329		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Baltimore County General Hospital		DUE TO, OR AS A CONSEQUENCE OF		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Bronchopneumonia		DUE TO, OR AS A CONSEQUENCE OF					
Cerebral infarction		DUE TO, OR AS A CONSEQUENCE OF					
Occlusion of int. carotid artery		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Cronio cerebral trauma					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 10 P.M. 3 6 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		21g. LOCATION Street or R.F.D. No. City or Town County State		21h. LOCATION Street or R.F.D. No. City or Town County State	
construction site		Unknown.					
22a. I certify that (I) (this hospital) attended the deceased from 3/6/69, 1969, to 4/21, 1969, that (we) (we) saw the deceased alive on 4/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
I.H. WEINER		4/23/69					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
1010 ST. PAUL ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		25 APR 69		Holy Redeemer Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lennon Funeral Home 4611 Heights		Baltimore		APR 28 1969		Charles Judge	

04284

STATE OF NEW YORK

IN SENATE

January 10, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

1900

ALBANY:

JOHN P. KANE, PRINTER

1901

ALBANY: J. P. KANE, PRINTER

1901

04284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 11 Film 411 4/16/69 kk					CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
George LeRoy Coleman Sr.					April 6, 1969			9 am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male.		White.		Sept 13, 1909		59 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.						Balto. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson.			3 Dellercrest Garth			Reg. Oper. Mgr.		Truck Rental.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Towson.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3 Dellercrest Garth.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
?			?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.			192-10-8698		Margaret L. Coleman. 3 Dellercrest Garth.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Death Myocardial Infarction.</i>										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <i>Chronic subacute Coronary Artery Disease</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>66</i> , to <i>April</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Francis T. Daly</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/8/69</i>			
22d. PHYSICIAN'S NAME (Type) Francis T. Daly, M.D.					22e. ADDRESS <i>11 E. Chase Street</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		April 9, 1969		Dulaney Valley Mem. Gardens		Balto. Co.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Paul E. Chenoweth Jr. 3615 Chestnut Ave.					APR 10 1969		<i>Paul E. Chenoweth Jr.</i>			

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

George Henry Colman Sr. April 1, 1908

White. April 1, 1908

x

White.

George Henry Colman Sr. April 1, 1908

White. April 1, 1908

April 1 - 1908. George Henry Colman Sr.

George Henry Colman Sr.

April 1, 1908. George Henry Colman Sr.

George Henry Colman Sr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ARTHUR BERNARD COMBS						April 14 1969			7:25 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years birthday)		IF UNDER 1 YEAR	
Male		Negro		9/12/1894		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH
Maryland		U.S.A.				Baltimore			Fort Howard
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Administration Hospital		Elevator Operator							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Baltimore				5231 Denmore Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William - - - Combs			Emma - - - Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
Yes WW-1			213 05 8218			Clinical Rcds, VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ARTERIOLE PHROS CLEROS IS									
DUE TO, OR AS A CONSEQUENCE OF									
(b) GENERALIZED ARTERIOSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c) DIABETES MELLITUS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
ARTERIOSCLEROTIC HEART DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 25, 19 69, to April 14 19 69, that (I) (we) lost the deceased alive on April 14 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (view) the body after death.									
22b. SIGNATURE J.D. Talbert, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 4/14/69	
22d. PHYSICIAN'S NAME (Type) J.D. TALBERT, M.D.								22e. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 18 / 69		Baltimore National		Baltimore, Maryland			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
ELLIOTT FUNERAL HOME		1129 N. Caroline St. Balto, Md.		APR 21 1969		J. Charles Jager			

RECEIVED

2011-13-02-0001

ATTENTION: MEDICAL RECORDS

12 million 4 31

• **W. C. F. C.**

FROM JACOBUS MULLER

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15-17 Film 12 5/5/69 kk 04987										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04979				
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR				
Oliver Charles Conn										Month 4 Day 24 Year 69										9:24 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN									
Male			White			7-21-81			87 YRS.															
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										Md.					
Baltimore			U.S.A.						Baltimore															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY															
Randallstown			BCGH			Ret. Steel Worker - Armco Steel																		
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER												
Md.			Baltimore			Balto.						5013 Reisterstown Rd.												
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																					
John Conn			Elizabeth Andria Andrews																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address															
NO			218-03-7732			Lillian			21215															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>D. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2/67</u> , 19 <u>67</u> , to <u>4/24/69</u> , 19 <u>69</u> , that (I) (we) saw the deceased alive on <u>4/22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Julius C. Gluck, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type) <u>Julius C. Gluck, M.D.</u>										22e. ADDRESS <u>5356 Reisterstown Road 21215</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)												
Burial			April 28, 69			Baltimore Cemetery						Baltimore Maryland												
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Loring Byers Chapel 8728 Liberty Rd. 21133										DATE APR 28 1969			<u>Charles Young</u>											

04227

UNITED STATES DEPARTMENT OF JUSTICE

U.S. DEPT. OF JUSTICE  
DIVISION OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04988

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04980

1. DECEASED-NAME (Type or print) <b>David Robert Conner</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>69</b>			2b. HOUR <b>5:50</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-I-65</b>		6. AGE (In years last birthday) <b>3</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dependent</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>203 Marborn Road</b>		14. FATHER'S NAME First <b>Gregory</b> Middle <b>Robert</b> Last <b>Conner</b>					
15. MOTHER'S MAIDEN NAME First <b>Barbara</b> Middle <b>Lynn</b> Last <b>Barton</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood's Records Owings Mills Md. 21117</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5609</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory arrest, secondary to above</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b> <b>4 Hours</b> <b>10 Minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>January 18, 1967</b> , to <b>April 30, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 30, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alan S. Greenberg M.D.</b> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-30-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Alan S. Greenberg M.D.</b>				22e. ADDRESS <b>Rosewood State Hospital Owings Mills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5-2-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 5 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (a)  
30M REV. 7/68

| 04989  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 04981   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |   |  |  |  |  |
| First Middle Last<br><b>ETHEL CONWAY</b>   |  |  |  |  |   |  |  |  |  | Month Day Year<br><b>APRIL 9, 1969</b>  |  |  |  |  |  |  |  |  |  | 3 <sup>40</sup> M                                   |  |  |  |  |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  |  |  | 4. RACE<br><b>NEGRO</b>   |  |  |  |  | 5. DATE OF BIRTH<br><b>5/5/20</b>   |  |  |  |  | 6. AGE (In years last birthday)<br><b>48</b> YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County,</b> Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived/admission) STATE<br><b>MARYLAND</b>   |  |  |  |  | 13b. COUNTY<br><b>—</b>   |  |  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 13e. STREET AND NUMBER<br><b>831 W. FAYETTE ST.</b> |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME<br><b>JOSEPH PEACE</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>?</b>  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br><b>?</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>                |  |  |  |  |   |  |  |  |  |
| 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |  |  |   |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4 as Advanced Pulmonary Tuberculosis</b><br><b>011.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Hepatic Insufficiency due to Laennec's Cirrhosis</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1969</b> , to <b>April 9, 1969</b> , that (I) (we) lost saw the deceased alive on <b>April 9, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>W. Newcomer</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED                                      |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE<br><b>4/14/69</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bah. Nat. Ancestral Cem.</b>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>James P. Caswell</b>  |  |  |  |  |   |  |  |  |  | ADDRESS<br><b>1712 W. North Ave.</b>  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 11 1969</b>       |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |  |  |  |  |

00000

UNITED STATES DEPARTMENT OF JUSTICE

IN RE: [illegible]

JOHN WILSON, Defendant

Albany, New York

County of Albany

State of New York

People of the State of New York

County of Albany

State of New York

County of Albany

State of New York

County of Albany

State of New York

County of Albany

State of New York

County of Albany

State of New York

County of Albany

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |  |  |   |  |
| 04990 CERTIFICATE OF DEATH 04982  |  |   |  |  |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>GEORGE RANDALL COOK</b>   |  |   |  |  | 2a. DATE OF DEATH <b>April 13</b> Day <b>13</b> Year <b>1969</b>                  |  |  | 2b. HOUR <b>1:15a</b> M                                 |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>8-24-11</b>  |   | 6. AGE (In years last birthday) <b>57</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Indiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during past 12 months, full or part time, even if retired) <b>Business Sales Engineer</b>                       |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Machinery</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Towson</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>563 Woodbine Ave.</b>         |  |
| 14. FATHER'S NAME First Middle Last <b>George William Cook</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Effie Alice Irvin</b>  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>Yes</b> (If yes give war and dates of service) <b>WW II</b>   |  |   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address <b>Family records</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 29</b> , 19 <b>69</b> , to <b>April 13</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 13</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE <b>Beatriz P. Dizon</b>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED <b>4-13-69</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Beatriz P. Dizon, MD</b>  |  |   |  | 22e. ADDRESS <b>7620 York Road, Towson, Md.</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)  |  | 23b. DATE <b>April 16, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>John Burns' Sons, Towson, Maryland</b>  |  |   |  | 25a. REC'D BY REGISTRAR DATE <b>APR 18 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |  |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 412  
5/6/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 04991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04983

|   |         |                              |  |  |      |   |                                |  |                                   |  |          |
|---|---------|------------------------------|--|--|------|---|--------------------------------|--|-----------------------------------|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |      | 20. DATE KNOWN OF DEATH   |                                |  | 2b. HOUR                          |  |          |
| EDWARD JAMES CORKRAN  |         |                              |  |  |      | Month Day Year  |                                |  | M                                 |  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS   |                                | 2c. DATE PRONOUNCED DEAD   |                                   |  | 2d. HOUR |
| male  | white   | 6 Oct. 1909                  | 87 59 YRS.   | MONTHS   | DAYS | HOURS   | MIN.                           | Month Day Year   | M                                 |  | M        |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |                                |  | Md.                               |  |          |
| Balto. Md.  |         | U.S.A.                       |  |  |      | Baltimore   |                                |  |                                   |  |          |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |
| Towson  |         |                              | St. Joseph   |  |      | Sheet Metal Worker  |                                |  | Martin Co.                        |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              |  | 13b. COUNTY  |      | 13c. CITY OR TOWN   |                                | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER   |          |
| Maryland  |         |                              |  | A.A. Co.   |      | Pasadena  |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | Rt. 2 Box 383  |          |
| 14. FATHER'S NAME   |         |                              |  | 15. MOTHER'S MAIDEN NAME   |      | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give name and dates of service)     |                                |  | 16b. SOCIAL SECURITY NO.          |  |          |
| (Unknown)   |         |                              |  | Corkran  |      | Lena  |                                |  | 215-05-6335                       |  |          |
| 17. INFORMANT   |         |                              |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109                           |      |   | 19. ADDRESS                    |  |                                   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |
| Leona Corkran - Wife  |         |                              |  | Coronary Occlusion   |      |   | Sudden                         |  |                                   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  | (b)  |      |   | DUE TO, OR AS A CONSEQUENCE OF |  |                                   |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |                              |  | (c)  |      |   |                                |  |                                   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                              |  |  |      |   |                                |  |                                   |  |          |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |      |   |                                | 20. AUTOPSY?   |                                   |  |          |
|   |         |                              |  |  |      |   |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |                              |  | 21b. TIME OF INJURY Month, Day, Year   |      |   |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |                                   |  |          |
|   |         |                              |  | HOUR A.M. P.M. 19  |      |   |                                |  |                                   |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |      |   |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |                                   |  |          |
|   |         |                              |  |  |      |   |                                |  |                                   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |      |   |                                |  |                                   |  |          |
| ACTUAL SIGNATURE  |         |                              |  | Charles F. O'Donnell, M.D.   |      |   |                                | 22b. DATE SIGNED   |                                   |  |          |
| EXAMINER'S NAME (Type)  |         |                              |  | Charles F. O'Donnell, M.D.   |      |   |                                | 4/3/69   |                                   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              |  | 23b. DATE  |      | 23c. NAME OF CEMETERY OR CREMATORY  |                                | 23d. LOCATION (City or Town) (County) (State)  |                                   |  |          |
| Burial  |         |                              |  | 5 May 1969   |      | Glen Haven Memorial PK.   |                                | Glen Burnie Md.  |                                   |  |          |
| 24. FUNERAL DIRECTOR  |         |                              |  |  |      | ADDRESS   |                                | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE   |          |
| Singleton Funeral Home  |         |                              |  |  |      | Glen Burnie, Md.  |                                | DATE MAY 2 1969  |                                   | Charles Judge  |          |

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |       |   |          |  |  |
|---|--|--|-------|---|----------|--|--|
| 04992   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |       |   |          | 04984  |  |
| CERTIFICATE OF DEATH  |  |  |       |   |          |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First | Middle  | Lost     | 2a. DATE OF DEATH<br>Month Day Year  |  |
| Thaddeus  |  |  | W.    |   | Crapster | April 13, 1969   |  |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH  |          | 6. AGE (In years last birthday)  |  |
| Male  |  | White  |       | Dec. 16, 1880   |          | 88 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. COUNTY OF DEATH   |  |
| Maryland  |  | USA  |       |   |          | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson  |  | Chesapeake Manor   |       | Farmer  |          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland  |  | Howard   |       | Woodbine  |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |       | 13e. STREET AND NUMBER  |          |  |  |
| First Middle Last   |  | First Middle Last  |       | RFD #112  |          |  |  |
| Mortimer D. Crapster  |  | Georgetta Warfield   |       |   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT   |          | Address  |  |
| No  |  | 219-01-6391  |       | Mrs Robert R. Brannan, Towson, Md.  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 years</u> |  |  |       |   |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Arteriosclerotic Cardiovascular Disease</u>  |  |  |       |   |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       | 20a. AUTOPSY?   |          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| January 1968  |  |  |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |          |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |          |  |  |
|   |  |  |       |   |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1968, to April 13, 1968, that (I) (we) last saw the deceased alive on April 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |       |   |          |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |       | 22d. PHYSICIAN'S NAME (Type)  |          | 22e. ADDRESS   |  |
| L. Mynton Gaines Jr. M.D.   |  | April 14, 1968   |       | L. Mynton Gaines Jr. M.D.   |          | 7800 York Rd. Baltimore, 21204   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY  |          | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |  | 4/16/69  |       | Crapster Family Cemetery  |          | Nr. Florence, Howard Co. Md.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |       | 25b. REGISTRAR'S SIGNATURE  |          |  |  |
| Olin L. Molesworth, Damascus, Md.   |  | APR 17 1969  |       | J. Charles Judge  |          |  |  |

04222

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04993

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04985

|  |                         |   |  |   |  |  |  |   |   |   |  |  |
|--|-------------------------|---|--|---|--|--|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>PAUL LORN CRAWFORD</b>  |                         | First   |  | Middle  |  | Last   |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>23</b> Year <b>1969</b> |   | 2b. HOUR <b>3:30</b> M <b>P</b>   |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>3/9/1910</b>   |  | 6. AGE (In years last birthday)<br><b>59</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS<br>HOURS<br>MIN   |   | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>23</b> Year <b>19</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Monkton</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Monkton Road</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Tree Surgent</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tree</b>    |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>Harford</b>   |  | 13c. CITY OR TOWN<br><b>Street</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  | 13e. STREET AND NUMBER<br><b>Jerry Road</b>   |   |   |  |  |
| 14. FATHER'S NAME<br><b>Mack Lorn Crawford</b>   |                         |   |  | First   |  | Middle   |  | Last  |   | 15. MOTHER'S MAIDEN NAME<br><b>Lora Smallridge</b>                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                         | (If yes give war or dates of service)<br><b>WW 2</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-01-5448</b>  |  | 17. INFORMANT<br><b>Velva M. Crawford</b>  |  |   | ADDRESS<br><b>RD #1</b><br><b>Street, Md. 21154</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |   |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |   |  |   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.<br><b>19</b>                              |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |   |  |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>A. M. France</b>  |                         | EXAMINER'S NAME (Type)<br><b>A. M. FRANCE</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | 22b. DATE SIGNED<br><b>4/23/69</b>                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>4/28/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Cave</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rock Cave, Upshur, W. Va.</b>                               |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles E. Kurtz</b>  |                         |   |  | ADDRESS<br><b>Jarrettsville, Md. 21084</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 28 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |                        |  |
|--|--|--|--|---|---|---|--|------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |                        | 2b. HOUR                                     |
| FRANK  |  |  | WILLIAM CRIST  |   |   | Month Day Year<br>April 18, 1969  |  |                        | 3:45 AM                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR        |  |
| Male   |  | White  |  | 9-21-11   |   | 57 YRS.   |  | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                        |  |
| Maryland   |  |  | USA  |   |   |   | Baltimore Md.  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                        | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson   |  |  | St. Joseph Hospital  |   |   | Bethlehem Steel   |  |                        | Clerk  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |                        | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Baltimore  |   | Baltimore   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>             |                        | 5219 Hazelwood Ave. 21206                    |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |                        |  |
| First Middle Last<br>Martin J. Crist   |  |  | First Middle Last<br>Elizabeth Murphy  |   |   |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |                        |  |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)<br>WWII  |  |  | 215-01-7113  |   | Bertha M. Crist - 5219 Hazelwood Avenue   |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>4109 |  |  |  |   |   |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |  |                        |  |
|  |  |  |  |   |   |   |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 6</u> , 19 <u>69</u> , to <u>April 18</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>April 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |   |   |  |                        |  |
| 22b. SIGNATURE<br><u>Artemio Villavania</u> DEGREE   |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |   | 22c. DATE SIGNED<br>4-18-69  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <u>DR. ARTEMIO VILLAVANIA, M.D.</u>   |  |  |  |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |                        |  |
| Burial   |  | 4-21-69  |  | Holy Redeemer Cemetery  |   | Baltimore, Maryland   |  |                        |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                        |  |
| John C. Miller Inc-6415 Belair Road  |  |  |  |   | APR 22 1969   |   | Charles Judge  |                        |  |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |                                     |  |  |  |
|--|--|--|--|---|--|--|--|-------------------------------------|--|--|--|
| 04995  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 04987  |  |                                     |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   |  | 2a. DATE OF DEATH  |  |                                     |  | 2b. HOUR                                     |  |
| First Middle Last<br>DORIS MAE CURRY   |  |  |  |   |  | 4 Month 24 Day 69 Year   |  |                                     |  | 6:35   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                     |  | IF UNDER 24 HRS.                             |  |
| FEMALE   |  | CAUCASIAN  |  | 7-14-24   |  | 44 YRS.  |  | MONTHS DAYS                         |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                     |  |  |  |
| Penna.   |  | U.S.A.   |  |   |  | BALTIMORE Md.  |  |                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                                     |  |  |  |
| BALTIMORE  |  | GREAT. BALT. MED. CENTR  |  |   |  |  |  |                                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER              |  |  |  |
| Maryland   |  | Baltimore  |  | 21234   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 8604 Willow Oak Road                |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |                                     |  |  |  |
| First Middle Last<br>John Brady  |  | First Middle Last<br>Cleo M. Fillmore  |  |   |  |  |  |                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |  |                                     |  |  |  |
| No   |  | 218 12 3974  |  | Clyde E. Curry 8604 Willow Oak Road   |  |  |  |                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SECONDARY CARCINOMATOSIS</u>  |  |  |  |   |  |  |  |                                     |  | TWO DAYS                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CARCINOMA OF BREAST/RIGHT</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |  |  |                                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |                                     |  |  |  |
| MEDICAL CERTIFICATION  |  |  |  |   |  |  |  |                                     |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                     |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |                                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |                                     |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                                     |  |  |  |
|  |  |  |  |   |  |  |  |                                     |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-8, 19 69, to 4-24, 19 69, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 4-24 19 69 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |  |   |  |  |  |                                     |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS.   |  | MED. DIRECTOR  |  | STAFF PHYS.                         |  | 22c. DATE SIGNED                             |  |
| W. E. Johnson  |  |  |  | <input type="checkbox"/>  |  | <input type="checkbox"/>   |  | <input checked="" type="checkbox"/> |  | 4-24-69                                      |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |  |  |  |                                     |  |  |  |
| WILLIAM YEH, M.D.  |  |  |  |   |  |  |  |                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)   |  | (County)                            |  | (State)                                      |  |
| Burial   |  | 4-28-69  |  | Parkwood Cemetery   |  | Baltimore  |  | County                              |  | Maryland                                     |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                     |  |  |  |
| William E. Johnson   |  | 8521 Loch Raven Blvd.  |  | MAY 1 1969  |  | Charles Judge  |  |                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |                                    |   |   |  |  |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|--|
| 04996  |  |                              |  |   |                                    |   |   |  |  |
| CERTIFICATE OF DEATH   |  |                              |  |   |                                    |   |   |  |  |
| 04988  |  |                              |  |   |                                    |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First Middle Last  |   |                                    | 2a. DATE OF DEATH<br>Month Day Year   |   |  | 2b. HOUR                                     |
| Domenica M. Dagostaro  |  |                              |  |   |                                    | April 19 69   |   |  | 6145   |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  |
| Female   |  | White                        |  | 6-19-98   |                                    | 70 YRS.   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |  |
| Italy  |  | U.S.A.                       |  |   |                                    | Baltimore Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson   |  |                              | St. Joseph Hospital  |   |                                    | Housewife   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 13e. STREET AND NUMBER   |  |
| Maryland   |  |                              | Baltimore  |   | Parkville                          |   |   | 8411 Harford Rd., 21234  |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |                                    |   |   |  |  |
| Philip Zanghi  |  |                              | Salvatora Miraglia   |   |                                    |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT                      |   | Address                                       |  |  |
| No   |  |                              | 216-05-9897  |   | Mr Sam Dagostaro                   |   | Same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br><u>4107</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction Acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cardio Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                              |  |   |                                    |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |   |                                    |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |
|  |  |                              |  |   |                                    |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18/</u> , 19 <u>69</u> , to <u>4/19/</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/19/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |  |   |                                    |   |   |  |  |
| 22b. SIGNATURE<br><u>Lilia C. Baldonado</u> DEGREE   |  |                              |  |   |                                    | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>4-19-69</u>                                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Lilia C. Baldonado M.D.</u>   |  |                              |  |   |                                    | 22e. ADDRESS<br><u>7620 York Rd., Towson, Md. 21204</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |  |  |
| Burial   |  |                              | 4/23/69  |   | Holy Redeemer                      |   | Baltimore, Maryland                           |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |                              |  |   |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |  |                              |  |   |                                    | APR 21 1969   |   | <u>Charles Judge</u>   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|
| Item 13 Film 111<br>4/11/69 kdc<br><b>04997</b>   |  |  |  |  |  |  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> |  |  |  |  |  |  |  |  |  | <b>04989</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print) <b>First BARBARA Middle L. Last DAILEY</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>April 3, 1969</b>                               |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>8:45</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Female</b>  |  |  |  |  |  |  |  |  |  | 4. RACE <b>White</b>   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) <b>39</b> YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> , 3, Year <b>1969</b> |  |  |  |  |  |  |  |  |  | 2d. HOUR <b>8:45</b> |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |  |  |  |  |  |  |  |  | Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Forest Haven Nursing Home</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurse</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  |  |  |  |  |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN <b>Catonsville</b>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER <b>117 Frederick Ave</b>                                  |  |  |  |  |  |  |  |  |  | <b>Ingleside Ave. Edmondson Ave</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME <b>First Charles Middle Louis Last DeBouck</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <b>First Cecelia Middle Theresa Last Anderson</b>   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>212- 24 - 2482</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS <b>Charles DeBouck Cumberland Md.</b>                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  | 571.8   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Arteriosclerotic cardiovascular disease</b>  |  |  |  |  |  |  |  |  |  | 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)     |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.  |  |  |  |  |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED <b>4-4-69</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE <b>April 7, 1969</b>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <b>APR 8 1969</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |

FOR JURY  
1947

04393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

1947

Married

Single

Widow

Divorced

Never

Other

Married

Single

Widow

Divorced

Never

Other

Signature of Medical Examiner

Signature of Coroner

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Signature of Juror

Unofficial Attestation

April 7, 1947

APR 4 1947



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                   |   |   |   |  |  |  |
|--|--|---|-------------------|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                   |   |   |   |  |  |  |
| 04998  |  |   |                   |   | 04990   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |                   |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>LOHMAN</b>  |  |   | First Middle Last |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>21</b> Year <b>69</b>  |   |  | 2b. HOUR<br><b>5:05</b> A.M.                                     |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |                   | 5. DATE OF BIRTH<br><b>3.1.1900</b>   |   | 6. AGE (In years last birthday)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hosp.</b> |                   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |                   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>Gaithersburg Md. 20760</b>          |  |
| 14. FATHER'S NAME<br><b>GEORGE DAVIS</b>   |  |   | First Middle Last |   | 15. MOTHER'S MARDEN NAME<br><b>EMMA HALL</b>  |   |  | First Middle Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arterial hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 1/2 hrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Far Advanced pulmonary Tuberculosis</b>  |  |   |                   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |                   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11.26</b> , 19 <b>68</b> , to <b>4.21</b> , 19 <b>69</b> , that (I) (we) lost the deceased alive on <b>4.21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  |   |                   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4.21.1969</b>                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |   |                   | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/24/69</b>   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Emory Grove Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Emory Grove Montg. Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>George R. Snowden</b>   |  |   |                   | ADDRESS<br><b>Rockville</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 24 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04999

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04991

|  |                  |  |   |   |  |   |  |   |  |   |  |
|--|------------------|--|---|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First  |   | Middle  |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year |  | 2b. HOUR<br>? M                                 |  |
| ALBERT   |                  | E.   |   |   |  | DEBAUGH   |  | April 17, 1969  |  | ?   |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>9-16-1895  | 6. AGE (In years<br>last birthday)<br>73 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month April Day 17, Year 19 69                        |  | 2d. HOUR<br>? M                                 |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Medical Center |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Electrician   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Railroad  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland  |                  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>110 Margate Rd.   |  |   |  |
| 14. FATHER'S NAME<br>Albert DeBaugh  |                  | First  |   | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME<br>Margaret Lewis  |  | First Middle Last                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) Yes  |                  | (If yes, give war or dates of service)<br>Ww 1   |   | 16b. SOCIAL SECURITY NO.<br>705-09-8084   |  | 17. INFORMANT<br>Bessie M. DeBaugh 110 Margate Rd. Lutherville  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4124<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |   |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                  |  |   |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                                  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |   |   |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE  |                  | Ronald N. Kornblum, M.D.   |   |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22b. DATE SIGNED<br>4/18/69   |  |   |  |
| EXAMINER'S<br>NAME (Type)  |                  | ADDRESS (Street, city, town, or county)  |   |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>4-21-1969   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |                  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 21 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...   |  |   |  |   |  |

0022-0715/97/0000-0000\$05.00/0

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1980-1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 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and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

|  |  |  |  |  |  |  |  |                                 |  |  |  |
|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|
| 05000  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                        |  |  |  | 04992  |  |                                 |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last Katherine T. E. Deckret   |  |  |  |  |  | 2a. DATE OF DEATH Month 4 Day 22 Year 69                             |  | 2b. HOUR 6 PM                   |  |  |  |
| 3. SEX Female  |  | 4. RACE White  |  | 5. DATE OF BIRTH Dec. 3, 1885  |  | 6. AGE (In years last birthday) 83 YRS.                              |  | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 |  | 8. UNDER 24 HRS HOURS 0 MIN. 0               |  |
| 7a. BIRTHPLACE (State or foreign country) Md.  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH Baltimore Md.                                     |  |                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH Catonsville.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE H. |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife - Char Ward  |  | 12b. KIND OF BUSINESS OR INDUSTRY Office Buildings                   |  |                                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md   |  | 13b. COUNTY 13c. CITY OR TOWN Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER 1434 Towson St.                               |  |                                 |  |  |  |
| 14. FATHER'S NAME First Middle Last Charles Thomas   |  | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Dingle                                   |  |  |  |  |  |                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No  |  | 16b. SOCIAL SECURITY NO. 218-18-3024   |  | 17. INFORMANT Address Records: Spring Grove State Hosp.  |  |  |  |                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema.  |  |  |  |  |  |  |  |                                 |  | 18 hrs                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pneumonitis.   |  |  |  |  |  |  |  |                                 |  | 4 weeks                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |                                 |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) A.S.C.V.D., Renal failure, Diverticulosis of the colon.   |  |  |  |  |  |  |  |                                 |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                                 |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                 |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 4-22-1967, to 4-22-1969, that (I) (we) last saw the deceased alive on 4-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                                 |  |  |  |
| 22b. SIGNATURE Diomidis L. Pirovolidis   |  | 22c. DATE SIGNED 4-22-69.  |  | 22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis   |  |  |  |                                 |  |  |  |
| 22e. ADDRESS Spring Grove St. Hosp. Baltimore, Md. 21268   |  |  |  |  |  |  |  |                                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE 4-26-69  |  | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery  |  | 23d. LOCATION (City or Town) Baltimore (County) Maryland             |  |                                 |  |  |  |
| 24. FUNERAL DIRECTOR Charles L. Stevens  |  | ADDRESS Funeral Home, Inc. 1501 East Fort Avenue   |  | 25a. REC'D BY REGISTRAR APR 24 1969  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                 |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV. 1/68

|  |  |  |  |   |   |  |   |  |              |
|--|--|--|--|---|---|--|---|--|--------------|
| 05001  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |  |   |   | 04993  |   |  |              |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>ANTOINETTE  |  | Middle<br>(Tena)  | Last<br>DEMORESKI   | 2a. DATE OF DEATH<br>APRIL Month 22, Day 1969          |   | 2b. HOUR<br>2:50AM   |              |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>SEPTEMBER 23, 1907  |   | 6. AGE (In years<br>last birthday)<br>61 YRS.          |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |              |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIAGE STATUS<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.                    |   |  |              |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>ST. JOSEPH HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOMEMAKER                                       |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Aetna Shirt Co |   |  |              |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>MARYLAND   |  | 13b. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET AND NUMBER<br>3200 PUTTY HILL AVE. #21234  |   |  |              |
| 14. FATHER'S NAME<br>First<br>Wladyslaw  |  | Middle<br>Brzozowski   |  | Last<br>Leokadya  |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Leokadya          |   | Middle<br>Popowski   |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>215-03-4476  |  | 17. INFORMANT<br>Address<br>Thomas Demoreski 3200 Putty Hill Ave 34   |   |  |   |  |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized metastatic carcinoma</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |   |   |  |   |  |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |  |   |  |              |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,)<br>OFFICE BUILDING, ETC.                        |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State |
| 22a. I certify that (X) (this hospital) attended the deceased from April 4, 1969, to April 22, 1969, that (X) (we) last saw the deceased alive on April 22, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.  |  |  |  |   |   |  |   |  |              |
| 22b. SIGNATURE<br><i>A. Villafania</i>   |  |  |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>April 22, 1969                                      |  |              |
| 22d. PHYSICIAN'S NAME (Type)<br>A. Villafania, M.D.  |  |  |  |   | 22e. ADDRESS<br>7620 York Road, Towson, Md. #21204  |  |   |  |              |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>4/25/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cemetery   |   | 23d. LOCATION (City or Town)<br>Baltimore 21224, Md    |   | (County) (State)   |              |
| 24. FUNERAL DIRECTOR<br>George A. Weber 705 South Ann Street   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 23 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                      |  |              |

**Abstract:**

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>05002</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 10 Film 411 4/14/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>04994</div>  |  |  |  |   |  |   |  |  |                                |
|--|--|--|--|---|--|---|--|--|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Frances</b>   |  |  |  | First <b>C.</b> Middle <b>Dettmer</b> Last  |  | 2a. DATE OF DEATH<br><b>4</b> Month <b>3</b> Day <b>69</b> Year   |  |  | 2b. HOUR<br><b>12:22</b> M     |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>April 26, 1896</b>   |  | 6. AGE (In years last birthday)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS                                | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1904 Glen Keith Blvd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>5128 Harford Road 21214</b> |                                |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>H.</b> Last <b>Deinlein</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Jennie</b> Middle <b>Neuberger</b> Last  |  |   |  |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-6220 D</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Lucille M. Holland 1904 Glen Keith Blvd</b>   |  |   |  |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinoma</b><br><b>1530</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Admo-Carcinoma of Rectum and Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/15/69</b> |  |  |  |   |  |   |  |  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |                                |
| 19a. DATE OF OPERATION<br><b>1/15/69</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of Colon</b>                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> ot work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>—</b>                     |  | 21f. LOCATION<br>Street or R.F.D. No. <b>1935</b> City or Town <b>4/3</b> County State  |  |   |  |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1935</b> , 19 <b>4/3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |                                |
| 22b. SIGNATURE<br><b>James E. White</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>April 3, 1969</b>                 |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>James E. White M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>5214 Harford Road Baltimore Maryland</b>   |  |   |  |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/5/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>  |  |  |                                |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc.</b>  |  |  |  | ADDRESS<br><b>5305 Harford Road 21214</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>       |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

OK - M.D. - J.M.D. 2  
med. 4 cert. 100% correct

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 05003  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                           |  |   |  | 04995   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>MARTHA LUCY DEVEREAUX   |  |   |  |   |  | 2a. DATE OF DEATH<br>April Month 23, 1969   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Aug. 29, 1915   |  | 6. AGE (In years last birthday)<br>53 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore County, Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Essex   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>217 Langley Rd. 21221 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Sec't.   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>217 Langley Rd. 21221                             |  |
| 14. FATHER'S NAME First Middle Last<br>Gustave Van Cutsen  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary p. Van Acker   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>061-03-2280   |  | 17. INFORMANT<br>Mr. Bernard A. Devereaux-217 Langley Rd.   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of the breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>174X</u><br><u>10 Mo</u> |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/69</u> , 19 <u>69</u> , to <u>4/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Raymond D. Bahr</u>   |  |   |  | 22c. DATE SIGNED<br><u>4/24/69</u>  |  | 22d. PHYSICIAN'S NAME (Type)<br>RAYMOND D. BAHR   |  |   |  |
| 22e. ADDRESS<br>ST. AGNES Hospital   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>Apr. 25, '69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>H. Sander & Sons, Inc., Balto., Md.  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 28 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |

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McKee's Caravan  
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KAYMOND D. BARR

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Providence Bazaar

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05004

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04996

|   |         |   |  |   |                           |  |                          |  |  |   |            |
|---|---------|---|--|---|---------------------------|--|--------------------------|--|--|---|------------|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle  |                           | Last   |                          | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> |  | 2b. HOUR  |            |
| RALPH   |         | EDGAR   |  | DIEHL   |                           | DIEHL  |                          | 19   |  | M   |            |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS |  | IF UNDER 24 HRS<br>HOURS |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |   | 2d. HOUR   |
| male  | white   | June 20, 43   |  | 25 YRS.   |                           |  |                          |  | April 29, 19 69                            |   | 10:15 A. M |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. COUNTY OF DEATH   |                          |  |  |   |            |
| Hampstead Md.   |         | U.S.A.  |  |   |                           | Baltimore  |                          |  |  | Md.   |            |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)         |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                           | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |                          |  |  |   |            |
| Owings Mills Md.  |         | 103 Enchanted Hills   |  | Plumber   |                           | Granston Pl.Co.  |                          |  |  |   |            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 13e. STREET AND NUMBER   |  |   |            |
| Maryland  |         | Baltimore   |  | Owings Mills  |                           |  |                          | 103 Enchanted Hills  |  |   |            |
| 14. FATHER'S NAME First Middle Last   |         |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |                           |  |                          |  |  |   |            |
| Harry Diehl   |         |   |  | Beulah Shaffer  |                           |  |                          |  |  |   |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |                           | 17. INFORMANT  |                          | Box 242 A. Windy Hill Rd   |  | ADDRESS   |            |
| NO  |         |   |  | 213-42-4257   |                           | Mrs. Marlene L. Diehl  |                          | Owings Mills Maryland  |  |   |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot Wound of Chest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |   |  |   |                           |  |                          |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |  |   |                           |  |                          |  |  |   |            |
| 19a. DATE OF OPERATION  |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |                           |  |                          | 20. AUTOPSY? (Part)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |            |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR:MIN: 4/28/19 69                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. shot self in chest   |                           |  |                          |  |  |   |            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>103 Enchanted Hills, Apt T1, Baltimore, Md.   |                           |  |                          |  |  |   |            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |   |                           |  |                          |  |  |   |            |
| ACTUAL<br>SIGNATURE   |         | Werner U. Spitz, M.D.   |  |   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                          | 22b. DATE SIGNED<br>4/29/69  |  |   |            |
| EXAMINER'S<br>NAME (Type)   |         |   |  |   |                           |  |                          |  |  |   |            |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                           |  |                          | 23d. LOCATION (City or Town) (County) (State)  |  |   |            |
| Burial  |         | 5/2/69  |  | Lake View Memorial Park   |                           |  |                          | Carroll County Maryland  |  |   |            |
| 24. FUNERAL DIRECTOR ADDRESS  |         |   |  |   |                           | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |  |   |            |
| Loring Byers 8728 Liberty Rd. Randallstown  |         |   |  |   |                           | MAY 5 1969   |                          | [Signature]  |  |   |            |

02002

DEPARTMENT OF THE ARMY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

June 20, 43

Employed at U.S.A.

Quincy Mills Co.

Lehigh Division

Quincy Mills Co.

Box 245, A. Quincy Mills  
Quincy Mills Co.

100-4557

Quincy Mills Co.

Lehigh Division

100-4557

MAY 6 1943

Quincy Mills Co., Lehigh Division

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-15-68  
30M REV. 11-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |   |   |                        |  |
|--|--|---|---|---|--|--|---|---|------------------------|--|
| 05005  |  |   |   |   | CERTIFICATE OF DEATH   |  |   | 04997   |                        |  |
| 1. DECEASED NAME<br>(Type or print)  |  |   | First Middle Last   |   | 2a. DATE OF DEATH<br>Month Day Year  |  |   | 2b. HOUR<br>Min.  |                        |  |
| Emily Crowley Ditman   |  |   |   |   | April 30 1969  |  |   | 4:25 AM   |                        |  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                              |                        |  |
| Female   |  | White   |   | Aug. 21, 1915   |  | 53 YRS.  |   |   |                        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |   |                        |  |
| Balto. Md.   |  | U.S.A.  |   |   |  | Baltimore Md.  |   |   |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                        |                        |  |
| Woodlawn   |  |   | 6605 Windsor Mill Rd.   |   |  | Housewife  |   | Home  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER |  |
| Md.  |  |   | Balto.  |   | Woodlawn   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   | 6605 Windsor Mill Rd.  |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |   |  |  |   |   |                        |  |
| Arthur Crowley, Sr.  |  |   | Zeta Biles  |   |  |  |   |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, NA (or unknown) (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Sr. Address   |  |   |   |                        |  |
| No   |  |   | 220-38-5428   |   | Mr. William F. Ditman 6605 Windsor Mill Rd.  |  |   |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral of brain equid metelosis</u><br>174X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>17 years |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |   |   |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                  |  |   |   |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                     |  |   |   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 8, 1952</u> , to <u>April 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |   |   |  |  |   |   |                        |  |
| 22b. SIGNATURE<br><u>Edwin E. Pierpont, M.D.</u>   |  |   |   |   | DEGREE<br>MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>4/30/69</u>  |   |                        |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>EDWIN E. PIERPONT, M.D.</u>   |  |   |   |   | 22e. ADDRESS<br><u>8224 LIBERTY PL. BALTO. 21207 MARYLAND</u>                                    |  |   |   |                        |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |   |                        |  |
| Burial   |  | May 3, 1969   |   | Lorraine  |  | Woodlawn Balto. Md.  |   |   |                        |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>John T. Stansbury, Sr. - 6411 Windsor Mill Rd.</u>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>MAY 2 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |                        |  |

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OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05006

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04996

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>ISRAEL</b>   |  | First Middle Lost   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 24 1969</b>   |  | 2b. HOUR<br><b>930 A M</b>  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>NOVEMBER 1877</b>  |  | 6. AGE (In years lost birthday)<br><b>91</b> YRS.   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6821 WESTRIDGE RD.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CARPENTER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOYED</b>                                       |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>UNKNOWN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>220-09-0535</b>  |  | 17. INFORMANT<br>Address<br><b>MRS. MINNIE SCHWARTZ, 6821 WESTRIDGE ROAD</b>                              |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>485X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 1969  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 1967</b> , to <b>April 24, 1969</b> , that (I) (we) lost saw the deceased alive on <b>April 23</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Howard H. Gendason MD.</b>   |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>April 24, 1969</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>HOWARD H. GENDASON MD.</b>   |  | 22e. ADDRESS<br><b>REISTERSTOWN, MARYLAND</b>   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-25-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BOBROIKER BENEFICIAL CIRCLE</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ROSEDALE, MARYLAND</b>                      |   |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 28 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                     |   |

36029

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14  
30M REV. 11/64

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 05007   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                              |  |   |  | 04999   |   |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>JOSEPH FRANCIS DOEMLING SR  |  |  |  |   |  | 2a. DATE OF DEATH<br>APRIL 19, 1969 Year  |   | 2b. HOUR<br>6:30 AM  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>2/1/92  |  | 6. AGE (In years last birthday)<br>77 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD, MD.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VETERANS ADMIN. HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>MOULDER  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>6902 HIGHVIEW AVENUE                   |  |
| 14. FATHER'S NAME First Middle Last<br>GEORGE DOEMLING  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>MARGARET - - MICHAEL                                       |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>YES WWI   |  | 16b. SOCIAL SECURITY NO.<br>216 07 2181  |  | 17. INFORMANT Address<br>CLINICAL RECORDS, VAH, FT. HOWARD, MD.   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CHRONIC RESPIRATORY FAILURE</u><br>519.2 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CHRONIC GRANULOMATOUS DISEASE OF LUNGS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MONTHS<br>YEARS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from APR 17, 19 69, to APR 19, 19 69, that (X) (we) lost saw the deceased alive on APR 19, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Alfonso A. Lopez  |  | DEGREE<br>APFONSO A. LOPEZ, MD.  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4 19 69   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>APFONSO A. LOPEZ, MD.   |  | 22e. ADDRESS<br>VAH, FT. HOWARD, MD.   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>APRIL 22 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER CEMETERY  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MD.                                 |   |  |  |
| 24. FUNERAL DIRECTOR<br>DIPPEL FUNERAL HOME   |  |  |  | ADDRESS<br>7110 BELAIR RD<br>BALTO., MD.  |  | 25a. REC'D BY REGISTRAR<br>APR 22 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>Judge                              |  |

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STATE OF TEXAS

IN SENATE,  
January 10, 1900.

REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1899.

BY  
JOHN W. HARRIS,  
COMMISSIONER.

RECEIVED  
JAN 11 1900  
STATE OF TEXAS  
LAND OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                  |  |   |   |   |
|---|------------------|--|---|---|---|
| 05008   |                  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 05000   |   |
| Item 13 Film 412 5/8/69 kk  |                  | CERTIFICATE OF DEATH   |   |   |   |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Donahue, Mary G. Miss.  |                  |  | 2a. DATE OF DEATH Month Day Year<br>April 28 1969   |   | 2b. HOUR<br>6:30 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>10-21-1873   |   | 6. AGE (In years lost birthday)<br>95 YRS.  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.              |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore Md   |                  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore, Md.  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Stella Maris Hospice                                   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Dressmaker |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |                  | 13b. COUNTY<br>BALTIMORE/TOWSON  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 13e. STREET AND NUMBER<br>2832 St. Paul Street<br>DULANEM / WILLY / MD. |
| 14. FATHER'S NAME First Middle Last<br>Thomas Donahue   |                  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Frances Hines   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |                  | 16b. SOCIAL SECURITY NO.<br>#215-32-0809   |   | 17. INFORMANT Address<br>A.A. MADORAH DONAHUE 101 W. MONUMENT   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD</u> |                  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic heart syndrome</u>  |                  |  |   |   |   |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                       |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work  |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 4/28, 1969, that (I) (we) last saw the deceased alive on 4/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |                  |  |   |   |   |
| 22b. SIGNATURE<br><u>David Nagel</u>  |                  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-28-69   |   |
| 22d. PHYSICIAN'S NAME (Type)<br>J. David Nagel M.D.   |                  | 22e. ADDRESS<br>812 Mockingbird Lane 21204   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 23b. DATE<br>5/1/69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CATHEDRAL   |   |
| 24. FUNERAL DIRECTOR<br>H. W. Mears   |                  | ADDRESS<br>805 N. Calvert St.  |   | 25a. REC'D BY REGISTRAR<br>DATE MAY 5 1969  |   |
|   |                  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>JAMES</b>   |  |  | First <b>G.</b> Middle <b>DONEY</b> Last   |   |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>9</b> Day <b>1969</b> Year   |   |  | 2b. HOUR<br><b>4:40</b> AM   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>3-10-1896</b>  |  |   | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Martin Co.</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5702 Beechdale Road</b>                   |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-16-8010</b>   |   | 17. INFORMANT<br><b>Mrs Esther B Doney</b>   |   | Address<br><b>Same</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>General arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>March 31</b> , 19 <b>69</b> , to <b>April 9</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>April 9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Gualberto Gokim, Jr.</b> DEGREE   |  |  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-9-69</b>                  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Gualberto Gokim, Jr., M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/11/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 9 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05010

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05002

|   |         |   |  |   |  |   |  |   |  |  |  |   |  |
|---|---------|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle  |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  | Month Day Year                             |  | 2b. HOUR  |  |
| Carroll   |         | M.  |  | Donnelly  |  |   |  | April 4 1969  |  | 5 PM                                       |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  | 2d. HOUR  |  |
| male  | white   | April 8, 1910   |  | 58 YRS.   |  |   |  |   |  | April 4 1969                               |  | 5 PM  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |  |  |   |  |
| Balto. Md.  |         | USA   |  |   |  | Baltimore   |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |  |  |   |  |
| Towson  |         | 963 Fairmount Ave.  |  | Retired Fireman Balto. City   |  |   |  |   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |  |  |   |  |
| Md.   |         | Balto.  |  |   |  |   |  | 963 Fairmount Ave.  |  |  |  |   |  |
| 14. FATHER'S NAME   |         | First   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First                                      |  | Middle Last                                     |  |
| Martin  |         | J.  |  | Donnelly  |  |   |  | Ella  |  |  |  | McNally   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, na, or unknown)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |   |  |
| no  |         | 216-05-2254   |  | Mrs. Helen C. Donnelly  |  | Same  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Strangulation from</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Hanging</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |         |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)     |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         |   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                        |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL<br>SIGNATURE <u>Charles F. Donnelly</u> M.D.   |         |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <u>4/4/69</u>  |  |  |  |   |  |
| EXAMINER'S<br>NAME (Type) <u>Charles F. Donnelly</u>  |         |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                         |  |  |  |   |  |
| ADDRESS (Street, city, town, or county)   |         |   |  |   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |  |  |   |  |
| burial  |         | 4/8/69  |  | New Cathedral   |  | Balto. Md.  |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR  |         |   |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                 |  |   |  |
| Mitchell-Wiedefeld Home 6500 York Rd. Balto.  |         |   |  |   |  | Md. 21212   |  | APR 9 1969  |  | Charles Judge                              |  |   |  |

02010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>05011</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film 4/22/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>05003</div>  |  |                              |  |  |  |  |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |                              |  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| <div>First</div> James <div>Middle</div> O'Brien <div>Last</div> Donnelly  |  |                              |  |  |  | <div>Month</div> April <div>Day</div> 13 <div>Year</div> 1969  |  |  | <div>12:47</div>   |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
| male   |  | white                        |  | 5-16-1897  |  | 71 72 YRS.   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |  |  |
| Ireland  |  | U.S.A.                       |  |  |  | Baltimore Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Towson   |  |                              | St. Joseph   |  |  | Farmer-retired   |  |  | Farm   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |                              | Baltimore  |  |  | Baltimore  |  |  |  | 17 Linden Terrace                            |  |
| 14. FATHER'S NAME  |  |                              |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| <div>First</div> James <div>Middle</div> Donnelly <div>Last</div>  |  |                              |  |  |  | <div>First</div> Elizabeth <div>Middle</div> Donnelly <div>Last</div>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  |  |  |  |
| No   |  |                              | None   |  |  | Family records   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diffuse Gastrointestinal bleeding</u><br>5699 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypoprothrombinemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                              |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                      |  |  |  |  |  |
|  |  |                              | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
|  |  |                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4-13</u> , 19 <u>69</u> , to <u>4-13</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4-13</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                              |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |                              |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED   |  |  |
| <u>L. Cillini M.D., DEGREE</u>   |  |                              |  |  |  |  |  |  | <u>4-13-69</u>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
| <u>INES CILLINI M.D.</u>   |  |                              |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |
| Burial   |  |                              | April 16, 1969   |  |  | St. John's Cemetery  |  |  | Long Green, Balto. Co., Md.  |  |  |
| 24. FUNERAL DIRECTOR   |  |                              |  |  |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| <u>John Burns' Sons, Towson, Maryland</u>  |  |                              |  |  |  | <u>APR 18 1969</u>   |  |  | <u>Johnas Judge</u>  |  |  |

1083

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK (100-100000)  
FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]  
[Illegible]

RE: [Illegible]  
[Illegible]

DATE: [Illegible]  
[Illegible]

BY: [Illegible]  
[Illegible]

FOR: [Illegible]  
[Illegible]

BY: [Illegible]  
[Illegible]

FOR: [Illegible]  
[Illegible]

BY: [Illegible]  
[Illegible]

FOR: [Illegible]  
[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 05012  |  | CERTIFICATE OF DEATH  |  |  |  |  |  | 05004   |  |
| 1. DECEASED-NAME (Type or print) <b>William Earl Dorfman</b>   |  | First Middle Last   |  | 2a. DATE OF DEATH <b>4 Month 8 Day 69<sup>ear</sup></b>  |  | 2b. HOUR <b>4:00<sup>p</sup></b>   |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH <b>11/5/86</b>  |  | 6. AGE (In years last birthday) <b>82</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County Gen.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MUSIC</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>INSTRUCTOR</b>  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>6741-C Townbrook Drive</b>    |  |
| 14. FATHER'S NAME First Middle Last <b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>126-14-4184</b>   |  | 17. INFORMANT <b>MRS. JENNIE DORFMAN, 6741 C TOWNBROOK DR.</b>   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |  |  |   |  |
| PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b>   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>PRIMARY CARCINOMA OF Rt LUNGS</b>  |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>PULMONARY EDEMA + CONGESTION</b>   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  |  |  |  |  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |  |  |  |  |   |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |   |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>  |  |   |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   |  |  |  |  |  |   |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <b>1969</b>  |  |   |  |  |  |  |  |   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |   |  |  |  |  |  |   |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |   |  |  |  |  |  |   |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Aurora T. Hipolito M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>4/8/69</b>   |  |   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>AURORA T. HIPOLITO M.D.</b> 22e. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>   |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>   |  |   |  |  |  |  |  |   |  |
| 23b. DATE <b>4-11-69</b>   |  |   |  |  |  |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>  |  |   |  |  |  |  |  |   |  |
| 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>   |  |   |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Sol LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  |   |  |  |  |  |  |   |  |
| 25a. REC'D BY REGISTRAR <b>APR 14 1969</b>   |  |   |  |  |  |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |                              |  |   |   |  |   |                       |  |
|---|------------------------------|--|---|---|--|---|-----------------------|--|
| 05013   |                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   |   |  | 05005   |                       |  |
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle  | Last  | 2a. DATE OF DEATH  |   | 2b. HOUR              |  |
| LEON  |                              |  | D.C.  | DOROSZ  | 4 14 69  |   | 9:20 P                |  |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR       |  |
| MALE  | CAUCASIAN                    |  | 12-11-09  |   | 59 YRS.  |   | MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |                       | Md.  |
| Maryland  | USA                          |  |   |   | BALTIMORE  |   |                       |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                       |  |
| BALTIMORE   |                              | GREAT BALT MED CENTER  |   | District Manager  |  | Food Fair Corp  |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER  |                       |  |
| Maryland  |                              | Baltimore  |   | Towson  |  | 8113 Bellona Avenue   |                       |  |
| 14. FATHER'S NAME   |                              | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |   |                       | First Middle Last                            |
| Anthony Dorosz  |                              |  |   |   | Unknown  |   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |   |                       | Address                                      |
| No  |                              | None   |   | 217-03-0599   |  |   |                       | Family records                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |  |   |   |  |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |                              |  |   |   |  |   |                       | 24 hrs                                       |
| IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u>  |                              |  |   |   |  |   |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |                              |  |   |   |  |   |                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                              |  |   |   |  |   |                       |  |
| (b) <u>CARCINOMA OF AMPULLA OF VATER WITH METASTASES</u>  |                              |  |   |   |  |   |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |                              |  |   |   |  |   |                       |  |
| (c)   |                              |  |   |   |  |   |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                              |  |   |   |  |   |                       |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                       |  |
| 4-12&13-69  |                              | CA OF AMULLA OF VATER AND POST-OP BLEEDING                                   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |   |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |                       |  |
|   |                              | HOUR A.M. Month Day Year   |   |   |  |   |                       |  |
|   |                              | P.M. 19  |   |   |  |   |                       |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION   |  |   |                       |  |
|   |                              |  |   | Street or R.F.D. No. City or Town County State  |  |   |                       |  |
| 22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>4-25</u> , 19 <u>69</u> , to <u>4-14</u> , 19 <u>69</u> , that <del>(I)</del> (we) lost <del>saw</del> the deceased alive on <u>4-14</u> , 19 <u>69</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) <del>(dissect)</del> view the body after death. |                              |  |   |   |  |   |                       |  |
| 22b. SIGNATURE  |                              |  |   | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                       | 22c. DATE SIGNED                             |
| <u>Richard C. Smith M.D.</u>  |                              |  |   |   |  |   |                       | <u>4-15-69</u>                               |
| 22d. PHYSICIAN'S NAME (Type)  |                              |  |   | 22e. ADDRESS  |  |   |                       |  |
| RICHARD SMITH, M.D.   |                              |  |   | 6701 N CHARLES ST   |  | BALT, MD  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |                       |  |
| Burial  |                              | April 17, 1969   |   | Holy Cross Cemetery   |  | Baltimore, Maryland   |                       |  |
| 24. FUNERAL DIRECTOR  |                              |  |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |                       | 25b. REGISTRAR'S SIGNATURE                   |
| John Burns Sons   |                              |  |   | Towson.   |  | DATE APR 18 1969  |                       | <u>Richard J. J...</u>                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05006

|   |  |                                     |   |   |   |  |   |   |   |                                    |   |  |
|---|--|-------------------------------------|---|---|---|--|---|---|---|------------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>WILLIAM                    | Middle<br>T.  | Last<br>DORSEY  | 2a. DATE OF DEATH<br>April Month 30 Day 1969 Year                       |  | 2b. HOUR<br>6A M  |   |   |                                    |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White                    |   | 5. DATE OF BIRTH<br>Dec. 21, 1883.  |   | 6. AGE (In years<br>last birthday)<br>85 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.     |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore, Md.   |   |   |   |                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Towson Convalescent Home |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Salesman |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Millinery |                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  |                                     | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>2958 Harford Rd.        |                                    |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Dorsey  |  |                                     | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Unknown  |   |   |  |   |   |   |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  |                                     | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |   | 17. INFORMANT<br>Address<br>Mr. Fred W. Dorsey, 9121 Covered Bridge Rd. |  |   |   |   |                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                     |   |   |   |  |   |   |   |                                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                                     |   |   |   |  |   |   |   |                                    |   |  |
| 19a. DATE OF OPERATION  |  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |   |                                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                |   |   |   |                                    |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |                                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10</u> , 19 <u>68</u> , to <u>April 30</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>April 30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) did (did not) view the body after death.    |  |                                     |   |   |   |  |   |   |   |                                    |   |  |
| 22b. SIGNATURE<br><u>Laurence C. Post M.D.</u>  |  |                                     |   |   |   | DEGREE<br>ATTENDING<br>PHYS.   |   | <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>4/30/69</u> |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>LAURENCE C. Post</u>  |  |                                     |   |   |   | 22e. ADDRESS<br><u>6805 York Rd Baltimore Md</u>   |   |   |   |                                    |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   |  |                                     | 23b. DATE<br><u>5/2/69.</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cemetery</u>          |  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>  |   |                                    |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>  |  |                                     |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><u>MAY 1 1969</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>  |   |                                    |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05015

CERTIFICATE OF DEATH

05007

|   |  |   |        |   |  |   |   |   |  |         |
|---|--|---|--------|---|--|---|---|---|--|---------|
| 1. DECEASED-NAME<br>(Type or print) <b>CARROLL</b>  |  |   | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>16</b> Year <b>1969</b>                              |   |   | 2b. HOUR<br><b>11:10</b> AM                        |         |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |        | 5. DATE OF BIRTH<br><b>5-16-1891</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN |  |         |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |  |         |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Center</b> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>E. &amp; P. Balto. Co.</b>                              |   |   |  |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |        | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1613 Four Georges Ct.</b>                |  |         |
| 14. FATHER'S NAME<br><b>Charles</b>   |  | First   | Middle | Last  |  | 15. MOTHER'S MAIDEN NAME<br><b>Anna</b>   |   | First   | Middle   | Last    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | (If yes give war or dates of service)   |        | 16b. SOCIAL SECURITY NO.<br><b>212-05-0600</b>  |  | 17. INFORMANT<br><b>Mrs. Bessie Drury</b>   |   | Address<br><b>1613 Four Georges Co.</b>                               |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |        |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of lung and diverticulitis</b>  |  |   |        |   |  |   |   |   |  |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES   |   |  |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)      |   |   |   |  |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |        |   | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |   | County State                                       |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/3, 1969</b> , to <b>4/16, 1969</b> , that (I) (we) last saw the deceased alive on <b>4/16, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |        |   |  |   |   |   |  |         |
| 22b. SIGNATURE<br><b>John E. Adams</b>  |  |   |        |   | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/16/69</b>                 |         |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M. D.</b>   |  |   |        |   | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>                              |   |   |   |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Apr. 19, 1969</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town)<br><b>Balto.</b>   |   | (County)<br><b>Md.</b>  |  | (State) |
| 24. FUNERAL DIRECTOR<br><b>Helma R. Hoffmann</b>  |  |   |        |   | ADDRESS<br><b>3218 Hudson St.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |         |
|   |  |   |        |   | DATE<br><b>APR 18 1969</b>   |   |   |   |  |         |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |   |  |  |  |                |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|----------------|--|--|
| 05016   |  |   |  |   | CERTIFICATE OF DEATH   |  |  |   |  | 05008  |  |                |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br><i>Alva</i>   |   | Middle<br><i>Gertrude</i>  |  | Last<br><i>Duckworth</i>   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR       |  |  |
|   |  |   |  |   |  |  |  |   | Month<br><i>April</i> Day<br><i>6</i> Year<br><i>69</i>                                |  |  | <i>8:30 PM</i> |  |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>W.</i>  |  | 5. DATE OF BIRTH<br><i>9-29-87</i>  |  |  | 6. AGE (In years<br>lost birth day)  |   | IF UNDER 1 YEAR<br>MONTHS<br><i>01</i> YRS.  |  | IF UNDER 24 HRS<br>HOURS<br><i>01</i> MIN. |                |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore County</i>  |   |  |  |  | Md.            |  |  |
| <i>Pennsylvania</i>   |  | <i>U.S.A.</i>   |  |   |  |  |  |   |  |  |  |                |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><i>Balto Co Gen Hosp.</i> |   |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><i>Nurse</i> |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                             |  |                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><i>Md.</i>  |  |   | 13b. COUNTY<br><i>Balto.</i>   |   | 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 13e. STREET AND NUMBER<br><i>3628 Eitemiller Rd.</i>                                   |  |  |                |  |  |
| 14. FATHER'S NAME   |  |   | First<br><i>Charles</i>  |   | Middle<br><i>Coleman</i>   |  | Last<br><i>May</i>   |   | 15. MOTHER'S MAIDEN NAME First<br><i>Annie</i> Middle<br><i>May</i> Last<br><i>May</i> |  |  |                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown)<br><i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |   | 17. INFORMANT<br><i>ANNA Smith-2117 Northland Rd<br/>B. Seibert, Balto. Co. Gen. Hosp.</i> |  |  |   |  |  |  |                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardium Infarction.</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) <i>ASHO</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>2 days</i> |  |                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><i>GI bleeding etiology unknown.</i>   |  |   |  |   |  |  |  |   |  |  |  |                |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 3, 1969</i> , to <i>April 6, 1969</i> , that (I) (we) last<br>saw the deceased alive on <i>April 3, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |   |  |  |  |   |  |  |  |                |  |  |
| 22b. SIGNATURE<br><i>Boon Varnas</i>  |  | DEGREE<br><i>BOON VARNAS IN.</i>  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  | 22c. DATE SIGNED<br><i>April 6, 69</i>   |  |   |  |  |  |                |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  | 22e. ADDRESS<br><i>ARMACOST FUNERAL CHAPEL</i>                                  |  |   |  |  |  |   |  |  |  |                |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><i>4-9-69</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LORRAINE Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>BALTO, Md</i>                    |  |   |  |  |  |                |  |  |
| 24. FUNERAL DIRECTOR<br><i>ARMACOST FUNERAL CHAPEL</i>  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><i>APR 8 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J Charles Judge</i>                                 |  |   |  |  |  |                |  |  |

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WESTERN OF OREGON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Items 10, 11, 13, 14 & 15<br>Film 4/11 4/17/69  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 05009   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 05017   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>BRIAN TIMOTHY DUKE  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>APRIL 8 69   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>1:30  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>MALE  |  |  |  |  | 4. RACE<br>CAU.  |  |  |  |  | 5. DATE OF BIRTH<br>6-20-68  |  |  |  |  | 6. AGE (In years lost birthday)<br>9 mos. YRS. 9                                  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTIMORE  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MARYLAND   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Baltimore Medical Center |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>1101 Meridene Drive                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Donald Duke  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Frances Duke   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GRAM NEG ROD SEPTICEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GRAM NEG PYODERMIA AND PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AGAMMAGLOBULINEMIA</u>                               |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>NONE  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  |   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |   |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 29, 1969</u> , to <u>APRIL 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>APRIL 8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles C. Brown, M.D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>APRIL 8, 1969  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CHARLES C. BROWN  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>6701 N. CHARLES STREET   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>4/12/69   |  |  |  |  |   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Liberian Mem. Cem.                          |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.           |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>THE LASSAHAN FUNERAL HOME   |  |  |  |  |  |  |  |  |  | 25a. REGISTRATION DATE<br>4/8/69   |  |  |  |  |   |  |  |  |  | 25b. REGISTRATION NO.<br>1969   |  |  |  |  |  |  |  |  |  | 25c. REGISTRATION SIGNATURE<br>Charles C. Brown                          |  |  |  |  |  |  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

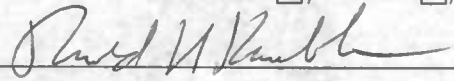
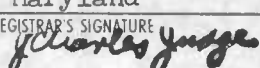
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05018

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05010

|  |                         |  |  |   |  |  |  |   |  |  |  |
|--|-------------------------|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                         | First<br><b>CLARA</b>  |  | Middle<br><b>ELIZABETH</b>  |  | Last<br><b>DUNKELBERGER</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> Month Day Year<br>MATED <input type="checkbox"/> April 11, 1969 |  | 2b. HOUR<br>7:30A                            |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>March 6, 1932</b>   | 6. AGE (In years last birthday)<br><b>37</b> YRS | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 11, 1969</b>   |  | 2d. HOUR<br>7:30A                            |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2410 Cidermill Road</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Manager Farmers Market</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>2410 Cedarmill Road</b>  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Charles Adam Roycroft</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Catherine Clark</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                         | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>218-26-0615</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>John Roycroft 2911 Rayshire Rd</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>965X</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>Unk. P.M. 4-11- 19 69</b>                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subj. shot by husband who inturn shot himself</b>                     |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)<br><b>Bedroom-Home</b>        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>2410 Cidermill Rd. Balto. Balto. M.D.</b>  |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |                         | EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br><b>4/11/69</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>4/14/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |                         |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 14 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>           |  |  |  |

31020

5501-0103

1991



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05019

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05011

|  |         |                              |  |   |                                |                                    |                               |  |                          |   |                |   |           |                   |  |
|--|---------|------------------------------|--|---|--------------------------------|------------------------------------|-------------------------------|--|--------------------------|---|----------------|---|-----------|-------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First                        |  | Middle  |                                | Last                               |                               | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |                          | Month Day Year                                |                | 2b. HOUR  |           |                   |  |
| MARLIN   |         | FOSTER                       |  | DUNKELBERGER  |                                |                                    |                               | April 11, 1969   |                          |   |                | 7:30 A.M.                                       |           |                   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |                                    | IF UNDER 24 HRS.<br>HOURS MIN |  | 2c. DATE PRONOUNCED DEAD |   | Month Day Year |   | 2d. HOUR  |                   |  |
| Male   | White   | 1/28/1920                    |  | 49 YRS.   |                                |                                    |                               |  | April 11, 1969           |   |                |   | 7:30 A.M. |                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH                 |                               |  |                          |   |                |   |           |                   |  |
| Pa.  |         | USA                          |  |   |                                | Baltimore                          |                               |  |                          |   |                |   |           |                   |  |
| 10. CITY OR TOWN OF DEATH  |         |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |                                |                                    |                               | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |                          |   |                | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |           |                   |  |
| Baltimore  |         |                              |  | 2410 Cidermill Road   |                                |                                    |                               | Auto Mechanic  |                          |   |                | Auto  |           |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |                              |  | 13b. COUNTY   |                                | 13c. CITY OR TOWN                  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 13e. STREET AND NUMBER                        |                |   |           |                   |  |
| Maryland   |         |                              |  | Balto.  |                                | Balto.                             |                               |  |                          | 2410 Cidermill Rd.                            |                |   |           |                   |  |
| 14. FATHER'S NAME  |         |                              |  | First   |                                | Middle                             |                               | Last   |                          | 15. MOTHER'S MAIDEN NAME                      |                |   |           | First Middle Last |  |
| Curtis Dunkelberger  |         |                              |  |   |                                |                                    |                               |  |                          | Pearl Crowl                                   |                |   |           |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |                              |  | 16b. SOCIAL SECURITY NO.  |                                | 17. INFORMANT                      |                               |  |                          | ADDRESS                                       |                |   |           |                   |  |
| Yes  |         |                              |  | WWII  |                                | 167241520                          |                               |  |                          | Blank Funeral Home Sunbury Pa 17801           |                |   |           |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u><br><u>955X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                              |  |   |                                |                                    |                               |  |                          |   |                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |           |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                              |  |   |                                |                                    |                               |  |                          |   |                |   |           |                   |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |                                |                                    |                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          |   |                |   |           |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                              |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 4-11- 19 69   |                                |                                    |                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Self-inflicted  |                          |   |                |   |           |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Bedroom-Home   |                                |                                    |                               | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>2410 Cidermill Rd. Balto. Balto. M.D.  |                          |   |                |   |           |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |   |                                |                                    |                               |  |                          |   |                |   |           |                   |  |
| ACTUAL<br>SIGNATURE  |         |                              |  | Ronald N. Kornblum, M.D.  |                                |                                    |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                          |   |                | 22b. DATE SIGNED<br>4/11/69                     |           |                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |                              |  | 23b. DATE   |                                | 23c. NAME OF CEMETERY OR CREMATORY |                               |  |                          | 23d. LOCATION (City or Town) (County) (State) |                |   |           |                   |  |
| Burial   |         |                              |  | 4/ 13/69  |                                | Millers Crossroads Cem             |                               |  |                          | Sunbury Pa.                                   |                |   |           |                   |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Balto. Md. 21214  |         |                              |  |   |                                |                                    |                               | 25a. REC'D BY REGISTRAR<br>DATE APR 14 1969  |                          | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                |   |           |                   |  |

05012

TOP SECRET  
RECEIVED



INVESTIGATION REPORT

CONFIDENTIAL

CONFIDENTIAL

## CERTIFICATE OF DEATH

05020

05012

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|-------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>BRICE</b>   |  |  | First <b>GILBERT</b>  |  |  | Middle <b>DU VAL</b>  |  |  | Last  |  |  | 2a. DATE OF DEATH<br>Month <b>04</b> Day <b>29</b> Year <b>69</b>   |  |  | 2b. <b>AM</b><br><b>5:45</b>  |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>CAU</b>   |  |  | 5. DATE OF BIRTH<br><b>6-08-29</b>  |  |  | 6. AGE (In years<br>last birthday)<br><b>39</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                            |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> Md.   |  |  |   |  |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MARYLAND</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital-<br>give street address)<br><b>GRF. BALTO. MED. CNTR.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Fire Fighter</b>   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>County Fire Dept.</b>                                |  |  |   |  |  |                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Essex 21221</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>471 Torner Road</b>                    |  |  |                               |  |  |
| 14. FATHER'S NAME<br><b>Joseph DuVal</b>   |  |  | First <b>Joseph DuVal</b>   |  |  | Middle  |  |  | Last  |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Evelyn Weide</b>               |  |  | Middle<br>Last                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)<br><b>Korean</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 24 0360</b>  |  |  | 17. INFORMANT<br><b>Wanda DuVal</b>   |  |  | Address<br><b>Same</b>  |  |  |   |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA OF LUNG RIGHT</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>11 MONTHS</b> |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br><b>NO</b> <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 29, 19 69</b> , to <b>APRIL 29, 19 69</b> , that (I) (we) lost<br>saw the deceased alive on <b>APRIL 29, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 22b. SIGNATURE<br><b>B. K. Choi, M.D.</b>  |  |  | DEGREE  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br><b>APRIL 29, 1969</b>   |  |  |   |  |  |                               |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>B. K. CHOI</b>   |  |  | 22e. ADDRESS<br><b>6701 NORTH CHARLES STREET</b>  |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>5/1/69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                      |  |  |   |  |  |                               |  |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home</b>   |  |  | Address<br><b>1407 Eastern Ave.</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 1 1969</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>  |  |  |   |  |  |                               |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02020

02020

02020

DATE: 10/10/1964 TIME: 10:10 AM

TO: DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/9/64.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 17-55

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05021

05013

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>JOHN PAUL DWAYER</b>   |  |  | 2a. DATE OF DEATH<br><b>April 8, 1969</b> Year                          |   |  | 2b. HOUR<br>M  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>2-6-1888</b>   |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Arbutus</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1270 Maple Avenue</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Arbutus</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1270 Maple Avenue</b>              |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>John Paul Dwayer</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Sarah R. Turner</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-5161</b>   |   | 17. INFORMANT<br>Address<br><b>Mrs. Lucille C. Walsh, 1228 Stevens Ave. 21227</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DISEASE OF CIRCULATORY COLLAPSE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEPATIC LIVER</b> |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 19 <b>64</b> , to <b>4/8</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/8</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Dr. John Shaw</b>   |  |  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>4/9/69</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br><b>5800 Edmondson Avenue, Balto., Md.</b>  |   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-12-1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 11 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05022

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05014

CERTIFICATE OF DEATH

|   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print) <i>Mary</i>   |  |  | First <i>A.</i>  |  |  | Middle <i>Ebberts</i>   |  |  | Last   |  |  | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>16</i> Year <i>1969</i> |  |  | 2b. HOUR<br>M <i>M</i>  |  |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>White</i>  |  |  | 5. DATE OF BIRTH<br><i>Oct. 21, 1890</i>  |  |  | 6. AGE (In years last birthday)<br><i>78</i> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i>                       |  |  | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i>                |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto., Md.</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |  |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Woodlawn</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>1519 Woodcliff Ave.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |  |  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>   |  |  | 13b. COUNTY <i>Baltimore</i>   |  |  | 13c. CITY OR TOWN <i>Woodlawn</i>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><i>1519 Woodcliff Ave.</i>                   |  |  |   |  |  |  |
| 14. FATHER'S NAME First <i>Franz</i> Middle <i>Reinhardt</i> Last   |  |  | 15. MOTHER'S MAIDEN NAME First <i>Marie</i> Middle <i>Boecker</i> Last                                     |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>  |  |  | (If yes give war or dates of service) <i>-----</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>212-05-2715B</i>   |  |  | 17. INFORMANT Address<br><i>Mrs. Emma Kemp-1519 Woodcliff Ave. 21228</i>                     |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i><br><i>4109</i> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coronary Artery Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Calcific Aortic Stenosis</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2-3 days</i> |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>Jan</i> , 19 <i>67</i> , to <i>4/16</i> , 19 <i>69</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>4/12</i> 19 <i>69</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>James Nolan</i>  |  |  | DEGREE   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><i>4/17/69</i>   |  |  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>J. S. NOLAN</i>  |  |  | 22e. ADDRESS<br><i>Baltimore Md 21229</i>  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>4/19/69</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadow Ridge Mem.</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Elkridge Howard Md.</i>                  |  |  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>John T. Stansbury, Sr.</i>   |  |  | ADDRESS<br><i>-6411 Windsor Mill Rd.</i>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 21 1969</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |  |   |  |  |  |

02032

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

1910

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|---|--|--|--|
| 05023   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201            |  |   |  | 05015  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Estelle H. Edson   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>4 - 26 - 69 |   |  | 2b. HOUR<br>10:25 AM   |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>8/27/1900   |  | 6. AGE (In years last birthday)<br>68 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BA/Ho.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cotonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Summit |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>BA/Ho.  |  | 13c. CITY OR TOWN<br>BA/Ho.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>3025 Beechfield Ave.  |  | 14. FATHER'S NAME<br>First Middle Last<br>Charles Foster                               |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Margaret Hedding   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>212-03-8766  |  | 17. INFORMANT<br>Address<br>Mrs. Earl Gable, 302 S. Beechfield Ave.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HYPERNEPHROMA</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CARCINOMATOSIS wide spread.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>69</u> , to <u>4/26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>E. KASARIS, M.D.</u>   |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>4/26/69</u>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>E. KASARIS, M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>1801 Frederick Road<br/>Baltimore Md 21228</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>4/29/69</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Crestlawn Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Howard County, Md</u>                                  |  |
| 24. FUNERAL DIRECTOR<br>Witzke, 4101 Edmondson Ave., 21229  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 29 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jager</u>  |  |



05024

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>Harry,</b>   |  | Middle <b>Farber</b>   |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>23</b> Year <b>1969</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH <b>9-6-1895</b>   |  |
| 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RICHMOND, VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9. COUNTY OF DEATH<br><b>Balto.</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Cnty. Gen. Hosp.</b>   |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PLUMBER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>   |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  |
| 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET AND NUMBER<br><b>8500 XXXXXXXXXX</b>  |  | 13f. CITY<br><b>BALTO.</b>   |  | 13g. STATE<br><b>MD.</b>   |  |
| 14. FATHER'S NAME First<br><b>CHARLES</b>   |  | Middle<br><b>FARBER</b>  |  | 15. MOTHER'S MAIDEN NAME First<br><b>IDA</b>   |  |
| Middle<br><b>SCHERR</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. II ARMY 213-03-7263</b>  |  |
| 17. INFORMANT<br><b>MR. IRWIN FARBER,</b>   |  | Address<br><b>8539 LUCERNE RD., #21133</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>4-23</b> , 19 <b>69</b> , to <b>4-23</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-23</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Gregorio Marfori, MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |
| 22c. DATE SIGNED<br><b>4-23-69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Gregorio Marfori, M.D.</b>  |  | 22e. ADDRESS<br><b>BCGH House Doctor</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-25-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                               |  | 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 28 1969</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |

02024

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1-68

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 05025   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  |   |  | 05017   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Cora E. Feaster   |  |   |  |   |  | 2a. DATE OF DEATH Month Day Year<br>Apr. 26 1969  |  | 2b. HOUR<br>9:25AM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>9-26-1875   |  | 6. AGE (In years last birthday)<br>93 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.     |  |
| 7a. BIRTHPLACE (State or foreign country)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Shangri La Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>At Home  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD   |  | 13b. CITY OR TOWN<br>Balto  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>4702 Springdale Ave.  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Charles Culler   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Effie Feaster   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO   |  | 16b. SOCIAL SECURITY NO.<br>NO  |  | 17. INFORMANT Address<br>Helen Dent - 2317 Birch Drive # 21207 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>4109</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>20 years</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>XXXXXXX   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>XXXXXXXXXXXXXXXXXXXXXXX                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? XXXXXXXXXXXXXXXX   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>XX                     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)<br>XXXXXXXXXXXX           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>XX  |  |   |  |  |  |
| 22a. I certify that (I) <u>(not)</u> attended the deceased from <u>1950</u> , to <u>April</u> , 19 <u>69</u> , that (I) <u>(not)</u> saw the deceased alive on <u>April 23</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(not)</u> (did) <u>(not)</u> view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Millard T. Traband, Jr.</u>  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/28/69                                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Millard T. Traband, Jr. M.D.  |  |   |  | 22e. ADDRESS<br>1811 N. Rolling Rd. Balt. Md. 21207   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-28-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Paul's Lutheran Cem   |  | 23d. LOCATION (City or Town) (County) (State)<br>Jefferson, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Armacost Funeral Chapel-4600 Liberty Hts.   |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 30 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>U. C. ...</u>                 |  |

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to study the reaction at temperatures between 10°C and 40°C. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

| Experimental Procedure                 |   |
|--|---|
| 1. Preparation of solutions            | 2. Measurement of the rate of reaction    |
| 3. Calculation of the rate of reaction | 4. Determination of the activation energy |
| 5. Conclusion                          |   |

The experimental procedure is as follows: 1. Preparation of solutions: A series of solutions of potassium iodate and hydrogen peroxide are prepared at different temperatures. 2. Measurement of the rate of reaction: The rate of reaction is measured by the volume of oxygen gas evolved over a fixed period of time. 3. Calculation of the rate of reaction: The rate of reaction is calculated from the volume of oxygen gas evolved and the time taken for the reaction to occur. 4. Determination of the activation energy: The activation energy is determined from the Arrhenius equation. 5. Conclusion: The effect of temperature on the rate of reaction is discussed, and the activation energy is determined.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05026   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05018                  |  |                  |  |
|---|--|--|--|--|--|--|--|------------------------|--|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR               |  |                  |  |
| Alice L. Ferrens  |  |  |  | Month 4 Day 5 Year 1969  |  |  |  | 9:55 AM                |  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS. |  |
| Female  |  | White  |  | 9/6/1882   |  | 88 YRS.  |  | MONTHS DAYS            |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |  | Md.              |  |
| Harford Co., Md.  |  | USA  |  |  |  | Baltimore  |  |                        |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |                  |  |
| Glendale  |  | 6709 Tweedbrook  |  | homemaker  |  |  |  |                        |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |                  |  |
| Md  |  | Balto  |  | Glendale   |  |  |  | 7609 Tweedbrook Rd.    |  |                  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                        |  |                  |  |
| First Middle Last   |  | First Middle Last  |  |  |  |  |  |                        |  |                  |  |
| Charles   |  | Ridgley  |  | Mary R. Mac Dow  |  |  |  |                        |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |                        |  |                  |  |
| No  |  | 218-32-0456  |  | Edith J. Ferrens   |  | 6709 Tweedbrook Rd.  |  |                        |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Secondary anemia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 yrs.<br>1 yr. |  |  |  |  |  |  |  |                        |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)  |  |  |  |  |  |  |  |                        |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                        |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                        |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 5, 1957, to April 5, 1969, that (I) (we) last saw the deceased alive on March 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |                        |  |                  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |  |  |                        |  |                  |  |
| Lloyd E. Saylor, MD   |  | Apr. 7, 1969   |  |  |  |  |  |                        |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |                        |  |                  |  |
| Dr. Lloyd E. Saylor   |  | 3902 Greenmount Ave  |  |  |  |  |  |                        |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                        |  |                  |  |
| Burial  |  | 4/8/1969   |  | Lorraine Cemetery  |  | Woodlawn Balto. Md.  |  |                        |  |                  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |                  |  |
| Mitchell Wiedefeld Home 6500 York Rd.   |  |  |  | APR 9 1969   |  | [Signature]  |  |                        |  |                  |  |

02050

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of 1994

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05027

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05019

|  |                  |  |  |   |  |   |   |  |
|--|------------------|--|--|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>MARGARET M. FETZ</b>  |                  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>APR. 20 1969</b> |   |  | 2b. HOUR <b>8:00</b> M.   |   |  |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>10/29/99</b>   | 6. AGE (In years last birthday) <b>69</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>             | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>20</b> Year <b>1969</b>               |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTO.</b>  |   |  |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>   |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1417 EASTERN</b>   |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |                  |  | 13b. COUNTY <b>BALTO</b>   | 13c. CITY OR TOWN <b>ESSEX</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <b>1417 EASTERN</b>  |   |  |
| 14. FATHER'S NAME First Middle Last <b>HENRY CUMBERLAND</b>  |                  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET KELLNER</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>  |                  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS <b>MICHAEL F. FETZ ABOVE</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA of Right Breast</b><br><b>174 X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastasis, Brain, liver etc</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY Month Day Year <b>May 1969</b><br>HOUR A.M. P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |  |   |   |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>   |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED <b>4/22/69</b>   |   |  |
| EXAMINER'S NAME (Type) <b>M.B. Davis</b>   |                  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                  |  | 23b. DATE <b>4/23/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>                                       |   | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b> |  |
| 24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>   |                  |  | ADDRESS <b>300 MAC</b>   |   |  | 25a. REC'D BY REGISTRAR <b>APR 24 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b> |

02027

RECEIVED - COMMUNICATIONS SECTION

URGENT 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

URGENT 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

[Large block of illegible text, likely a teletype or message body]

URGENT 10/10/54

TO: DIRECTOR, FBI



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05020

|  |  |  |                          |   |        |   |  |  |          |  |      |
|--|--|--|--------------------------|---|--------|---|--|--|----------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle  | Last   | 2a. DATE OF DEATH   |  |  | 2b. HOUR |  |      |
| ALFRED THOMAS FINNEY   |  |  |                          |   |        | APRIL Month 2 Day 1969 Year   |  |  | 1:30 M   |  |      |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |        | 6. AGE (In years birth day)   |  | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS.   |      |
| MALE   |  | NEGRO  |                          | May 2, 1892   |        | 76 YRS.   |  | MONTHS   |          | DAYS   |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH  |  |  | Md.      |  |      |
| VIRGINIA   |  | U.S.A.   |                          |   |        | BALTIMORE   |  |  |          |  |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL   |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |        | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |          |  |      |
| FORT HOWARD  |  | VETERANS ADMINISTRATION HOSPITAL   |                          | MINISTER  |        |   |  |  |          |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |          |  |      |
| MARYLAND   |  |  |                          | BALTIMORE   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1308 Rutter Street   |          |  |      |
| 14. FATHER'S NAME  |  |  | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |  | First    | Middle   | Last |
| GEORGE   |  |  |                          |   | FINNEY | NORA  |  |  | --       | --   | --   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO. |   |        | 17. INFORMANT   |  |  |          |  |      |
| YES  |  |  | WW-1                     |   |        | 217 09 7322 Clinical Recds VA Hospital, Fort Howard, Md.  |  |  |          |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u><br><u>4369</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |                          |   |        |   |  |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 MONTH</u> |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |   |        |   |  |  |          |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   |        | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |          |  |      |
|  |  |  |                          |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |          |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |        |   |  |  |          |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |        |   |  |  |          |  |      |
|  |  |  |                          |   |        |   |  |  |          |  |      |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Mar 31</u> , 19 <u>69</u> , to <u>April 2</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.        |  |  |                          |   |        |   |  |  |          |  |      |
| 22b. SIGNATURE<br><u>Peter J. Jovan</u>  |  |  |                          |   |        | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>4 2 69</u>                                    |          |  |      |
| 22d. PHYSICIAN'S NAME (Type)<br><u>PETER V. JUVAN, M. D.</u>   |  |  |                          |   |        | 22e. ADDRESS<br><u>VA Hospital, Fort Howard, Md.</u>  |  |  |          |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |        | 23d. LOCATION (City or Town)  |  | (County)   |          | (State)  |      |
| BURIAL   |  | <u>4-7-69</u>  |                          | <u>BALTIMORE NATIONAL CEMETERY</u>  |        | <u>BALTIMORE</u>  |  |  |          | <u>MARYLAND</u>  |      |
| 24. FUNERAL DIRECTOR<br><u>Phillips Funeral Home</u><br><u>1727 N. Monroe St.</u>  |  |  |                          | 25a. REC'D BY REGISTRAR<br><u>APR 8 1969</u>  |        | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |          |  |      |

02020

DATE: MAY 2, 1961  
TIME: 10:00 AM  
LOCATION: 1000 S. JEFFERSON ST.  
CITY: ST. LOUIS, MO.  
STATE: MISSOURI  
ZIP: 63102  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
COMMUNICATIONS SECTION  
TELEPHONE: 475-1000  
TELETYPE: 475-1000  
FAX: 475-1000  
CABLE: 475-1000  
RADIO: 475-1000  
MAIL: 475-1000  
POSTAL: 475-1000  
AIRMAIL: 475-1000  
EXPRESS: 475-1000  
COURIER: 475-1000  
TRUCK: 475-1000  
BOAT: 475-1000  
PLANE: 475-1000  
SHIP: 475-1000  
RAILROAD: 475-1000  
BUS: 475-1000  
TAXI: 475-1000  
CAR: 475-1000  
MOTORCYCLE: 475-1000  
BICYCLE: 475-1000  
WALK: 475-1000  
SWIM: 475-1000  
SKI: 475-1000  
BOAT: 475-1000  
PLANE: 475-1000  
SHIP: 475-1000  
RAILROAD: 475-1000  
BUS: 475-1000  
TAXI: 475-1000  
CAR: 475-1000  
MOTORCYCLE: 475-1000  
BICYCLE: 475-1000  
WALK: 475-1000  
SWIM: 475-1000  
SKI: 475-1000

RECEIVED: MAY 2, 1961  
FROM: ST. LOUIS, MO.  
SUBJECT: [REDACTED]  
REFERENCE: [REDACTED]  
ACTION: [REDACTED]  
STATUS: [REDACTED]  
COMMENTS: [REDACTED]  
APPROVED: [REDACTED]  
DATE: MAY 2, 1961  
BY: [REDACTED]  
TITLE: [REDACTED]  
DEPARTMENT: [REDACTED]  
DIVISION: [REDACTED]  
SECTION: [REDACTED]  
UNIT: [REDACTED]  
OFFICE: [REDACTED]  
STATION: [REDACTED]  
CITY: [REDACTED]  
STATE: [REDACTED]  
ZIP: [REDACTED]  
COUNTRY: [REDACTED]  
WORLD: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |   |   |  |                                |  |
|---|--|--|--|--|--|---|--|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |   |   |  |                                |  |
| 05029   |  |  |  |  | 05021  |   |  |   |   |  |                                |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Margarette  |  | Middle<br>Marie  |   | Last<br>Fisher                             |   | 2a. DATE OF DEATH<br>4 Month 16 Day 69 Year |  | 2b. HOUR<br>12:50M             |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>12/1/27  |  |   | 6. AGE (In years last birthday)<br>41 YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS              |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED<br>WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Clerk |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Industrial                             |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |  | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>107 E. Burke Ave                                  |   |  |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>George L. Neely   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Katherine Burke |  |  |   |  |   |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220 24 1578  |  | 17. INFORMANT<br>William E. Fisher   |  |   |  | 107 E. Burke Ave<br>Towson Md   |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |   |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |   |  |   |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>69</u> , to <u>4/16</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |   |   |  |                                |  |
| 22b. SIGNATURE<br>John E. Adams   |  | DEGREE   |  | ATTENDING PHYS.  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22c. DATE SIGNED<br>April 16, 1969  |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M. D.  |  | 22e. ADDRESS<br>6701 N. Charles St., Baltimore, Md. 21204  |  |  |  |   |  |   |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-19-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>David Ridge  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto Md                                       |  |   |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Higinbottom-Slack   |  | 24b. ADDRESS<br>Elliott City, Md   |  | 25a. REC'D BY REGISTRAR<br>APR 21 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>V. L. ...   |  |   |   |  |                                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |   |  |                        |  |
|---|--|--|--|--|---|---|---|--|------------------------|--|
| 05030   |  |  |  |  |   |   |   |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |  |                        |  |
| 05022   |  |  |  |  |   |   |   |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR               |  |
| Fleming S. Ford   |  |  |  |  |   | April 22, 1969  |   |  | 12:15 a.               |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR                              |                        |  |
| male  |  | white  |  | March 20, 1893   |   | 76 YRS.   |   | MONTHS DAYS HOURS MIN                        |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |                        |  |
| Va.   |  | U. S.  |  |  |   | Baltimore Md.   |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |                        |  |
| Catonsville   |  |  | SPRING GROVE STATE HOSP.   |  |   | printer   |   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Pr. Geo.   |  | Brsdbury Park   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 2211 Gaylord Drive     |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |  |                        |  |
| John S. Ford  |  |  | Louella Jones  |  |   |   |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |   |  |                        |  |
| yes   |  |  | 1917-18  |  | Records: SPRING GROVE STATE HOSPITAL                                |   |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |   |   |   |  |                        |  |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>   |  |  |  |  |   |   |   |  |                        |  |
| 4270 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |   |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |   |   |   |  |                        |  |
| (b) <u>Congestive heart failure</u>   |  |  |  |  |   |   |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |   |  |                        |  |
| (c)   |  |  |  |  |   |   |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |   |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                        |  |
|   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |  |                        |  |
|   |  | HOUR A.M. Month Day Year   |  |  |   |   |   |  |                        |  |
|   |  | P.M. 19  |  |  |   |   |   |  |                        |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   |   |   |  |                        |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | Street or R.F.D. No. City or Town County State   |   |   |   |  |                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 5, 1963</u> , to <u>April 22, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 22, 1969</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(not) (did)</u> view the body after death. |  |  |  |  |   |   |   |  |                        |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED       |  |
|   |  |  |  |  |   |   |   |  | 4-23-69                |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS  |   |   |  |                        |  |
| Rafael H. Marin, M.D.   |  |  |  |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228            |   |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |   | (County) (State)                             |                        |  |
| BURIAL  |  | 4/28/69  |  | BALTO. NATIONAL Cem  |   | BALTO.  |   | Md.  |                        |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |
| E. S. Mac Nabb  |  |  |  |  | APR 25 1969   |   | Charles Judge   |  |                        |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05023

|  |         |  |         |   |   |   |  |
|--|---------|--|---------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  | Middle  | Last  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 4/14/ 19 69                         |   | 2b. HOUR<br>6:30<br>P. M.                            |
| LILLIAN  |         | M.   |         | FORLIFER  |   |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |         | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year 19 69     |
| female   | white   | April 24, 1925   |         | 43 YRS.   |   |   | 2d. HOUR<br>6:43<br>P. M.                            |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland  |         | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore   |  |
| 10. CITY OR TOWN OF DEATH<br>Fullerton   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>4920 Hazelwood Avenue |         |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Self-Employed-Waste |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Oil Business |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |         | 13b. COUNTY<br>Baltimore   |         | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|  |         |  |         |   |   | 13e. STREET AND NUMBER<br>4920 Hazelwood Avenue   |  |
| 14. FATHER'S NAME  |         | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |   | First Middle Last                                    |
| Edward   |         | Thomas   | Leonard |   | Marie   |   | Cole   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>212-20-0799                         |         | 17. INFORMANT<br>Miss Sandra M. Forlifer  |   | ADDRESS<br>(Same)   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br><u>4122</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |         |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |         |   |   |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |         |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                          |         | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |         |   |   |   |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)   |         | Werner U. Spitz, M.D.  |         |   |   | 22b. DATE SIGNED<br>4/15/69   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |         | 23b. DATE<br>4/18/69.  |         | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214   |         |  |         | 25a. REC'D BY REGISTRAR<br>DATE APR 17 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Jurek  |  |

RECEIVED  
FEBRUARY 1962

00001

MEDICAL EXAMINER - CERTIFICATE OF DEATH

|                           |  |                                  |  |
|---------------------------|--|----------------------------------|--|
| Name of Deceased          |  | Date of Death                    |  |
| Sex                       |  | Age                              |  |
| Race                      |  | Place of Birth                   |  |
| Occupation                |  | Cause of Death                   |  |
| Manner of Death           |  | Signature of Medical Examiner    |  |
| Date of Examination       |  | Signature of Coroner             |  |
| Signature of Registrar    |  | Signature of Burial Officer      |  |
| Signature of Undertaker   |  | Signature of Cemetery            |  |
| Signature of Funeral Home |  | Signature of Religious Authority |  |
| Signature of Family       |  | Signature of Friends             |  |
| Signature of Neighbors    |  | Signature of Community           |  |
| Signature of Church       |  | Signature of Synagogue           |  |
| Signature of Mosque       |  | Signature of Temple              |  |
| Signature of Other        |  | Signature of Other               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05024

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Elsie Mae Foxwell</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>3</b> Year <b>1969</b> |   |  | 2b. HOUR<br><b>8:24</b>  |  |
| 3. SEX<br><b>F.</b>  |  | 4. RACE<br><b>W.</b>  |   | 5. DATE OF BIRTH<br><b>Oct. 28, 1890</b>  |  | 6. AGE (In years lost birthday)<br><b>78</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1114 Sleepy Dell Court</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>James</b> Middle <b>Hall</b> Last <b>Sarah</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Sarah</b> Middle <b>Daugherty</b> Last <b>Daugherty</b>                  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-2876</b>  |   | 17. INFORMANT<br>Address <b>Mrs Virginia E. Lewis 1114 Sleepy Dell</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>82 yr</b> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Carcinoma of Breast &amp; metastases to liver &amp; bone</b>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>Feb 20 1968</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel obstruction</b>                                  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June, 1953</b> to <b>Apr 3, 1969</b> , that (I) <del>last</del> saw the deceased alive on <b>Mar 15, 1969</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>N.R. Freeman</b>  |  |   |   | 22c. DATE SIGNED<br><b>4/4/69</b>   |  | 22d. PHYSICIAN'S NAME (Type) <b>Norman R. Freeman M.D.</b>                                   |  |
| 22e. ADDRESS<br><b>11 West 29th Street</b>   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4/5/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Md.</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

03030

OFFICE OF THE

UNITED STATES DEPARTMENT OF THE INTERIOR

03030

1991

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |         |                 |  |
|---|--|--|--|--|--|--|--|--|---------|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |         |                 |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |         |                 |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH  |         |                 | 2b. HOUR                                     |
| John  |  | L.   |  | Francis  |  | April 4, 1969  |  |  | 5:25 AM |                 |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |         | IF UNDER 24 HRS |  |
| Male  |  | White  |  | 5-9-1898   |  | 70 YRS.  |  | MONTHS   |         | DAYS            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |         |                 |  |
| Maryland  |  | USA  |  |  |  | Baltimore Md.  |  |  |         |                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |         |                 |  |
| Towson  |  | St. Joseph Hospital  |  | Retired - carpenter  |  | self employee  |  |  |         |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |         |                 |  |
| Maryland  |  | Baltimore Co.  |  |  |  |  |  | 1801 E. Joppa Rd. 21234  |         |                 |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |         |                 |  |
| John C. Francis   |  |  |  | Mary M. Eppig  |  |  |  |  |         |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |  |         |                 |  |
| No  |  | None   |  | 213-05-2624 Family records   |  |  |  |  |         |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |         |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |         |                 |  |
| IMMEDIATE CAUSE (a) Myocardial Infarction, Massive  |  |  |  |  |  |  |  |  |         |                 |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |         |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |         |                 |  |
| (b) Generalized Arteriosclerosis  |  |  |  |  |  |  |  |  |         |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |         |                 |  |
| (c)   |  |  |  |  |  |  |  |  |         |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |         |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |         |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |         |                 |  |
| HOUR A.M. Month Day Year  |  | P.M. 19  |  |  |  |  |  |  |         |                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town   |         | County State    |  |
|   |  |  |  |  |  |  |  |  |         |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 30, 1969, to April 4, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |         |                 |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |         |                 |  |
| Gualberto Gokim, Jr.  |  | April 4, 1969  |  |  |  |  |  |  |         |                 |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |  |         |                 |  |
| Gualberto Gokim, Jr. M.D.   |  |  |  |  |  |  |  |  |         |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)   |         | (State)         |  |
| Burial  |  | April 7, 1969  |  | Moreland Memorial Park   |  | Parkville, Maryland  |  |  |         |                 |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |         |                 |  |
| John Burns' Sons, Towson, Maryland  |  | APR 10 1969  |  | Charles Judge  |  |  |  |  |         |                 |  |

05033

CERTIFICATE OF DEATH

John C. Pannia

John C. Pannia

21927-2691 Family records

none

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John C. Pannia, 21927-2691 Family records

John C. Pannia, 21927-2691 Family records



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 05034   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                         |  |  |  | 05026  |  |
| 1. DECEASED-NAME (Type or print) <i>CLARENCE</i> First Middle Last <i>ELLMER FREELAND</i>   |  |   |  |  |  | 2a. DATE OF DEATH <i>12</i> Month <i>1969</i> Year <i>3 12</i> 2b. HOUR <i>PM</i>  |  |
| 3. SEX <i>Male</i>  |  | 4. RACE <i>White</i>  |  | 5. DATE OF BIRTH <i>November 21, 1898</i>  |  | 6. AGE (In years last birthday) <i>70</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                     |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.  |  |
| 10. CITY OR TOWN OF DEATH <i>Phoenix</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Paper Mill Road</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired.) <i>Carpenter</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>   |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN <i>Phoenix</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER <i>Paper Mill Road</i> |  |
| 14. FATHER'S NAME First Middle Last <i>Joseph Freeland</i>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Angela Nace</i>                                       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>None</i>  |  | 16b. SOCIAL SECURITY NO. <i>None</i>  |  | 17. INFORMANT Address <i>Family records</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Heart disease</i><br><i>4124</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>1969</i>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1936</i> , to <i>4/12</i> , 1969, that (I) ( <del>we</del> ) last saw the deceased alive on <i>4/10/69</i> 19, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <i>A. M. France</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>  |  | 22e. ADDRESS <i>PARKTON, Md</i>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 23b. DATE <i>April 15, 1969</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State) <i>Cockeysville, Maryland</i>  |  |
| 24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>  |  |   |  | 25a. REC'D BY REGISTRAR <i>Charles Jones</i>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05035

CERTIFICATE OF DEATH

05027

|  |  |  |  |   |  |   |   |  |  |  |  |  |
|--|--|--|--|---|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Mamie</b>  |  | First<br><b>Mamie</b>  |  | Middle<br><b>Friese</b>   |  | Last<br><b>Friese</b>   |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>12</b> Year <b>69</b> |  |  | 2b. HOUR<br><b>5.20 PM</b>                 |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>8-23-1886</b>  |  |   | 6. AGE (In years last birthday)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____         |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____ |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSE WIFE</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>410 Wamper Rd., -21224</b>              |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>CARL ROCKEL</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY THEIS</b>   |  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>WM. P. FRIESE</b>   |   |  | Address<br><b>ABOVE</b>                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction - Pulmonary Thrombosis</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____ 19 _____             |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)                              |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                         |   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/24/</b> , 19 <b>69</b> , to <b>4/12/</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/12/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. Banderas M.D.</b>  |  |  |  |   | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-12-69</b>                 |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. Banderas M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>7620 York Rd., Towson Md., 21204</b>  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/15/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ZION LUTHERAN</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>  |  |  |  |   | ADDRESS<br><b>300 MACE</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |  |

MEDICAL CERTIFICATION

05035

STATE OF TEXAS

IN SENATE, FEBRUARY 11, 1903.



REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE, FOR THE YEAR 1902.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |                                    |   |  |  |  |
|--|--|--|------------------------------------|---|--|--|--|
| 05036  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                    |   |  | 05028  |  |
| CERTIFICATE OF DEATH   |  |  |                                    |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle                             | Lost  | 2a. DATE OF DEATH  |  | 2b. HOUR   |
| MARIE  |  | E.   |                                    | FULLER  | April 19, 1969   |  | 11:05 A M  |
| 3. SEX   |  | 4. RACE  |                                    | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)                                      | IF UNDER 1 YEAR<br>MONTHS DAYS                         |
| Female   |  | White  |                                    | 12-3-1902   |  | 66 YRS.  | IF UNDER 24 HRS.<br>HOURS MIN                          |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Maryland   |  | U.S.A.   |                                    |   |  | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| Catonsville  |  | Summit Nursing Home  |                                    | Retired   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER   |  |
| Maryland   |  | Baltimore  |                                    | Woodlawn  |  | 6725 Kincheloe Avenue 21207  |  |
| 14. FATHER'S NAME  |  | First  | Middle                             | Lost  | 15. MOTHER'S MAIDEN NAME   |  |  |
| Joseph   |  | Serra  |                                    |   | Lillian (Unknown)  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT   |  |  |  |
| No   |  | 220-07-9851A   |                                    | Mr. Thomas J. Fuller, 6725 Kincheloe Avenue   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Obstructive Airway Disease (Bronchitis)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |                                    |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Lymphosarcoma</u>   |  |  |                                    |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>59</u> , to <u>4-19</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |                                    |   |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |                                    | 22d. PHYSICIAN'S NAME (Type)  |  |  |  |
| <u>John F. Schaefer</u>  |  | 4-20-69  |                                    | Dr. John F. Schaefer  |  |  |  |
| 22e. ADDRESS   |  | 22f. ADDRESS   |                                    | 22g. ADDRESS  |  |  |  |
| 401 Random Road, Baltimore, Maryland   |  |  |                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| BURIAL   |  | 4-23-1969  | Lorraine Park Cemetery             |   | Woodlawn, Maryland   |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |                                    | 25a. RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Howard H. Hubbard, 4107 Wilkens Ave.   |  | 21229  |                                    | APR 23 1969   |  | <u>Richard J. Judge</u>  |  |

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>05037</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>05029</div>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |                           |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>WILLIAM</b>  |  |  | Middle<br><b>GAYLORD</b>  |  |  | Last<br><b>GAYLORD</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>30</b> Year <b>69</b> |  |  | 2b. HOUR<br><b>7:15AM</b> |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>NEGRO</b>  |  |  | 5. DATE OF BIRTH<br><b>12/15/96</b>   |  |  | 6. AGE (In years last birthday)<br><b>72</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                |  | IF UNDER 24 HRS<br>HOURS<br>MIN              |                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |  |  |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Steel Worker</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b>  |  |  |  |  |  |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1324 Ellwood Avenue</b>             |  |  |                           |  |
| 14. FATHER'S NAME<br>First <b>ELLIS</b> Middle <b>GAYLORD</b> Last <b>THORPS</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>SUSIE</b> Middle <b>THORPS</b> Last <b>THORPS</b>                   |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>YES</b> (If yes give year or dates of service) <b>WW I</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213 09 30 95</b>  |  |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSP. FT HOWARD, MD.</b>   |  |  |  |  |  |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4319</b> IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CEREBRAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS, CLINICAL</b>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>              |  |  |  |  |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |                           |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>4/17/69</b> , 19____, to <b>4/30/69</b> , 19____, that <b>he</b> (we) last saw the deceased alive on <b>4/30/69</b> , 19____, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) <b>not</b> view the body after death.          |  |  |  |  |  |   |  |  |  |  |  |  |  |  |                           |  |
| 22b. SIGNATURE<br><b>John D. Talbert MD</b>   |  |  |  |  |  |   |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><b>4/30/69</b>           |                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |  |  |  |  |  |  |                           |  |
| 23a. BURIAL, CREMATION, or other disposition<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>May 5/69</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                  |  |  |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>ELLIOTT FUNERAL HOME MAY 1 1969</b><br><b>1129 N. Caroline St. Baltimore, Md.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>1 1969</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |  |  |                           |  |

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## RESULTS

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1. *Journal of Management Studies*, 1997, 34, 1.

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AGRICULTURE 111

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PORT BOARD

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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4. ON CHARGE OF THE COURT: 2000-2001

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• **EXHIBIT** •

DAVID L. HOWARD, PH.D.

... ..

GRAHAM, MICHAEL

1990 年 12 月 20 日

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                      |  |   |   |   |   |  |  |  |                         |
|---|----------------------|--|---|---|---|---|--|--|--|-------------------------|
| <div>05038</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05030</div>  |                      |  |   |   |   |   |  |  |  |                         |
| 1. DECEASED-NAME (Type or Print) <b>GEORGE</b>  |                      |  |   |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>April 18, 1969</b> |   |  |  |  | 2b. HOUR <b>7:15 AM</b> |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>March 13, 1912</b>   | 6. AGE (In years last birthday) <b>56</b> RS.                               | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>18</b> , Year <b>1969</b>   |  |  | 2d. HOUR <b>7:15 AM</b>                      |                         |
| 7a. BIRTHPLACE (State or foreign country) <b>Greece</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U, S A</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Baltimore</b>   |  |  |  |                         |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4029 North Point Blvd.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Owner North Star Inn</b>                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |                         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Dundalk</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>4029 North Point Blvd.</b> |  |                         |
| 14. FATHER'S NAME First <b>Simon</b> Middle <b>Georgandis</b> Last <b>Despina</b>   |                      |  | 15. MOTHER'S MAIDEN NAME First <b>Despina</b> Middle <b>?</b> Last <b>?</b> |   |   |   |  |  |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                      | 16b. SOCIAL SECURITY NO. <b>216-32-8127</b>  |   | 17. INFORMANT <b>Mrs Grace Georgandis</b>   |   |   | ADDRESS <b>Same</b>  |  |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>965X</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                      |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                      |  |   |   |   |   |  |  |  |                         |
| 19a. DATE OF OPERATION  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY Month, Day, Year <b>April 18, 1969</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot during robbery</b>  |   |   |  |  |  |                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Building</b>               |   | 21f. LOCATION Street or R.F.D. No. <b>4029 North Point Blvd.</b>  |   | City or Town <b>Balto.</b>  |  | State <b>M.D.</b>                                    |  |                         |
| 22a. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |   |   |   |   |  |  |  |                         |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>  |                      | EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                    |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>     |  |                         |
|   |                      |  |   | ADDRESS (Street, city, town, or county)   |   | 22b. DATE SIGNED <b>4/18/69</b>   |  |  |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 23b. DATE <b>4/21/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>          |  |  |  |                         |
| 24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc Baltimore, Maryland</b>  |                      |  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR <b>APR 21 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>      |  |                         |

05033

MINNESOTA STATE DEPARTMENT OF HEALTH

REPORT OF THE STATE DEPARTMENT OF HEALTH

APRIL 15, 1912

121-13-121

REPORT OF THE STATE DEPARTMENT OF HEALTH

APRIL 15, 1912

REPORT OF THE STATE DEPARTMENT OF HEALTH

APRIL 15, 1912

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                             |  |   |   |
|---|-----------------------------|--|---|---|
| 1. DECEASED NAME<br>(Type or print) <b>LILLIAN</b> First Middle Last  |                             | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>2</b> Year <b>1969</b>                                |   | 2b. HOUR<br><b>5:40</b> P.M.  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>caucasian</b> | 5. DATE OF BIRTH<br><b>Oct. 29, 1888</b>   |   | 6. AGE (In years lost birthday)<br><b>80</b> YRS.   |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |                             | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holly Hill Manor</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Frederick</b>   |                             | 13b. CITY OR TOWN<br><b>Thurmont</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>Rd. #1 Box 34</b>  |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas A. German</b>  |                             | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Laura V. Timmons</b>                                |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |                             | 16b. SOCIAL SECURITY NO.<br><b>220-30-3468</b>   |   | 17. INFORMANT<br>Address<br><b>Mrs. Mildred Hudson 2708 Grindon Avenue #14</b>                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4124 <del>Ascribed with</del> heart failure (anoxia)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus (14 yrs)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 year</b> |                             |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                             |  |   |   |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                             | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                           |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                             | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1952</b> to <b>April 1969</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 29 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                             |  |   |   |
| 22b. SIGNATURE<br><b>Wm. H. Kammer, Jr.</b>   |                             | 22c. DATE SIGNED<br><b>4/2/69</b>  |   | 22d. PHYSICIAN'S NAME (Type) <b>Dr. William H. Kammer, Jr.</b>  |
| 22e. ADDRESS<br><b>6011 York Road, Balto, Md.</b>   |                             |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                             | 23b. DATE<br><b>4/5/69.</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>  |                             |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc.-Baltimore, Md.-14</b>  |                             | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 2 1969</b>  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                             |  |   |   |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication from the President to the Congress since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Union at that time. It is a document that is well worth reading, and it is one that should be kept in every library.

2. The second part of the document is a letter from the Secretary of the War to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the War to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the War at that time. It is a document that is well worth reading, and it is one that should be kept in every library.

3. The third part of the document is a letter from the Secretary of the Navy to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the Navy to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Navy at that time. It is a document that is well worth reading, and it is one that should be kept in every library.

4. The fourth part of the document is a letter from the Secretary of the Treasury to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the Treasury to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Treasury at that time. It is a document that is well worth reading, and it is one that should be kept in every library.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 05040  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  |   |  | 05032   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CAMILLE L</b>   |  |   | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>7</b> Year <b>69</b>                                 |  | 2b. HOUR<br><b>6:20 P.M.</b>                                     |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>7-7-1880</b>   |  | 6. AGE (In years last birthday)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>CONANTON KY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALT. CO.</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT. Md.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6305 Boxwood Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSE WIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>  |  | 13b. COUNTY<br><b>D.C.</b>  |  | 13c. CITY OR TOWN<br><b>WASH/DC</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4458 RESERVOIR Rd</b>               |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>EDWARD C. HOPPER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>MARY K. BAILEY</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>NO</b>                         |  | 17. INFORMANT<br><b>MISS BARBARA Gibbs</b>  |  | Address <b>DC, 4458 RESERVOIR Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4123 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 min</b>     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1. Hypostatic pneumonia 2. Pulmonary emphysema</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1968</b> , to <b>April 7, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edward F. Cotter M.D.</b>   |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>April 7, 1969</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>EDWARD F. COTTER</b>   |  |   |  | 22e. ADDRESS<br><b>827 Linden Ave, Balto. Md</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-9-1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH GAWLER'S SON, INC.</b><br><b>8130 WISC. AVE., N. W. WASH., D. C. 20018</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 14 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Judge</b>  |  |  |  |

05010

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Cotton" and "seed" are faintly visible.]*

APR 11 1911  
RECEIVED  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OF ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, and 7 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |
| 05041  |  |  |  |  |  |   |  |  |   |  |  |
| 05033  |  |  |  |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>Harry   |  |  | Middle<br>Goldfadim   |  |  | Last  |  |  |
| 2a. DATE OF DEATH  |  |  | 4  |  |  | Month   |  |  | Day 69  |  |  |
| 2b. HOUR   |  |  | 4:20   |  |  | P.M.  |  |  |   |  |  |
| 3. SEX   |  |  | Male   |  |  | 4. RACE   |  |  | White   |  |  |
| 5. DATE OF BIRTH   |  |  | 3-25-1887  |  |  | 6. AGE (In years last birthday)   |  |  | 82  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | Russia   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | U.S.A.  |  |  |
| 8. MARRIED   |  |  | <input checked="" type="checkbox"/> NEVER MARRIED                            |  |  | WIDOWED   |  |  | <input type="checkbox"/> DIVORCED   |  |  |
| 9. COUNTY OF DEATH   |  |  | Baltimore  |  |  | County  |  |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | Randallstown   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |  |  | Balto. Co. Gen. Hospital  |  |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | PROPRIETOR   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | FURNITURE STORE   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | Maryland   |  |  | 13b. COUNTY   |  |  | Balto   |  |  |
| 13c. CITY OR TOWN  |  |  | Randallstown   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13e. STREET AND NUMBER   |  |  | 3624   |  |  | Templar Rd.   |  |  |   |  |  |
| 14. FATHER'S NAME  |  |  | First  |  |  | Middle  |  |  | Last  |  |  |
| DAVIS  |  |  | FOLDFADIM  |  |  | MIRIAM  |  |  | ?   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | NO   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 110-10-0199A  |  |  |
| 17. INFORMANT  |  |  | MRS. BEATRICE GOLDFADIM  |  |  | Address   |  |  | 3624 TEMPLAR ROAD   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | PART I. DEATH WAS CAUSED BY:   |  |  | IMMEDIATE CAUSE (a)   |  |  | Cardiovascular arrest (Cardiac arrhythmia)  |  |  |
| 4123   |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  | (b)   |  |  | Atherosclerotic Heart Disease   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  | (c)   |  |  | YEARS   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |   |  |  |
| HOUR A.M. Month Day Year   |  |  | P.M. 19  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION   |  |  | Street or R.F.D. No. City or Town County State  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-1, 1967, to 4-1, 1967, that (I) (we) last saw the deceased alive on 4-1, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE   |  |  | ANGELITA TOPACIO   |  |  | DEGREE  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  | ANGELITA TOPACIO   |  |  | 22e. ADDRESS  |  |  | B.C.M.  |  |  |
| 22c. DATE SIGNED   |  |  | 4-1-67   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |
| BURIAL   |  |  | 4-2-69   |  |  | MIKRO KODESH BETH ISRAEL  |  |  | BALTIMORE, MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD   |  |  |  |  |  | APR 3 1969  |  |  | Charles Judge   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (1)  
30M REV. 11/60

|   |  |  |                   |   |  |  |  |
|---|--|--|-------------------|---|--|--|--|
| 05042   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |                   |   |  | 05034  |  |
| Item #7 taken from prev. birth c  |  |  |                   |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES Jr. BENNETT GOLDSBOROUGH</b>   |  |  | First Middle Last |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>20</b> Year <b>69</b> |  | 2b. HOUR<br>M                                |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |                   | 5. DATE OF BIRTH<br><b>8/21/67</b>  |  | 6. AGE (In years last birthday)<br><b>1</b> YRS.                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>OWINGS MILLS Baltimore</b> Md.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ROSEWOOD STATE HOSPITAL</b> |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>none</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>PG</b>  |                   | 13c. CITY OR TOWN<br><b>Suitland</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>3105 Parkway Terrace Dr.</b>   |  | 14. FATHER'S NAME<br>First Middle Last<br><b>CHARLES BENNETT GOLDSBOROUGH</b>                                  |                   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>NELLIE LINDA LEIGH GOLDSBOROUGH</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>  |                   | 17. INFORMANT<br><b>Charles B. Goldsborough, Sr.</b><br><b>3105 Parkway Terrace Drive, Apt. 6</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia.</b><br><b>7439</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congenital Cerebral defect.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypoxic Encephalopathy.</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Jan. 29, 1969</b> , to <b>April 20, 1969</b> , that (we) last saw the deceased alive on <b>April 20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                   |   |  |  |  |
| 22b. SIGNATURE<br><b>Massoud Kaye</b>   |  |  |                   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>MD.</b><br><b>Owings Mills</b>                                |  |
| 22d. PHYSICIAN'S NAME (Type) <b>MASSOUD KAYE</b>  |  |  |                   | 22e. ADDRESS<br><b>Rosewood State Hospital, Box 137</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>4/23/69</b>  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bladensburg, Md.</b>             |  |
| 24. FUNERAL DIRECTOR<br><b>A. E. Wilhelm, Suitland, Md.</b>   |  |  |                   | 25a. REC'D BY REGISTRAR<br><b>APR 23 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>V. C. ...</b>                                       |  |

02042

U.S. DEPARTMENT OF AGRICULTURE

UNITED STATES

OFFICE OF THE SECRETARY

CHARLES J. BARNETT - FLD-EDWARDS

W. V.

UNITED STATES

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05043

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05035

|   |         |   |  |  |  |   |  |   |  |                          |  |        |  |      |  |  |  |
|---|---------|---|--|--|--|---|--|---|--|--------------------------|--|--------|--|------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle   |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  | Month                    |  | Day    |  | Year |  | 2b. HOUR<br>M  |  |
| Anthony   |         | A.  |  | Golembieski  |  |   |  | 4   |  | 7                        |  | 19     |  | 69   |  | 4:45   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (in years<br>last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD |  | Month  |  | Day  |  | Year   |  |
| Male  | Cau.    | 1-11-04   |  | 65 YRS.  |  |   |  |   |  | 4                        |  | 7      |  | 1969 |  | 4:45   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>      |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  | 9. COUNTY OF DEATH  |  |                          |  |        |  |      |  |  |  |
| Balto., Md.   |         | U. S. A.  |  |  |  |   |  | Baltimore   |  |                          |  |        |  |      |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |                          |  |        |  |      |  |  |  |
| Dundalk   |         | 203 Willow Spring Rd.   |  |  |  |   |  |   |  |                          |  |        |  |      |  | Beth. St.  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |                          |  |        |  |      |  |  |  |
| Md.   |         | Balto   |  | Dundalk  |  |   |  | 203 Willow Spring Rd.   |  |                          |  |        |  |      |  |  |  |
| 14. FATHER'S NAME   |         | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First                    |  | Middle |  | Last |  |  |  |
| John Golembieski (Deceased)   |         |   |  |  |  |   |  | Lillian ? (Deceased)  |  |                          |  |        |  |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |                          |  |        |  |      |  |  |  |
| No.   |         | 213-07-7898   |  | Catherine Golembieski  |  | Spring Rd.  |  |   |  |                          |  |        |  |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u><br>1621<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |   |  |  |  |   |  |   |  |                          |  |        |  |      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 L |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |  |  |  |   |  |   |  |                          |  |        |  |      |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                          |  |        |  |      |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. _____ 19 _____     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |   |  |   |  |                          |  |        |  |      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____       |  |   |  |   |  |                          |  |        |  |      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |  |  |   |  |   |  |                          |  |        |  |      |  |  |  |
| ACTUAL<br>SIGNATURE <u>Theodore C. Patterson</u> M.D.   |         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |  | 22b. DATE SIGNED  |  |                          |  |        |  |      |  |  |  |
| EXAMINER'S<br>NAME (Type) Theodore C. Patterson M.D.  |         | ADDRESS (Street, city, town, or county) 3427 Dundalk Ave.,                      |  |  |  |   |  |   |  |                          |  |        |  |      |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |         | 23b. DATE<br>4-9-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary Cemetery                                 |  | 23d. LOCATION (City or Town) (County) (State)<br>Dundalk, Maryland                              |  |   |  |                          |  |        |  |      |  |  |  |
| 24. FUNERAL DIRECTOR<br>John M. Weber & Sons Inc.   |         | ADDRESS<br>401, S. Chester St.  |  | 25a. REC'D BY REGISTRAR<br>APR 9 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |                          |  |        |  |      |  |  |  |

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05044

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05036

|  |  |                     |                       |  |  |   |  |   |                       |   |  |   |  |  |                        |     |  |                                     |  |
|--|--|---------------------|-----------------------|--|--|---|--|---|-----------------------|---|--|---|--|--|------------------------|-----|--|-------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                     | First<br><b>Irvin</b> |  |  | Middle<br><b>Baxter</b>   |  |   | Last<br><b>Gorman</b> |   |  | 2a. DATE KNOWN OF DEATH<br>Month <u>4</u> Day <u>8</u> Year <u>1969</u>                         |  |  | 2b. HOUR<br><u>2</u> M |     |  |                                     |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b> |                       | 5. DATE OF BIRTH<br><b>1/26/91</b>   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>  |                       | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b>                  |  | 2c. DATE PRONOUNCED DEAD<br>Month <u>4</u> Day <u>8</u> Year <u>1969</u>                        |  |  | 2d. HOUR<br><u>2</u> M |     |  |                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  |                     |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       |   |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |                        | Md. |  |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |                     |                       | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dairy</b>   |                       |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dairy</b>   |  |  |                        |     |  |                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |                     |                       | 13b. COUNTY<br><b>Baltimore</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                       |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>208 D Rodgers Forge 21212</b> |                        |     |  |                                     |  |
| 14. FATHER'S NAME<br>First <b>William G.</b> Middle <b>G.</b> Last <b>Gorman</b>   |  |                     |                       |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Frances E.</b> Middle <b>E.</b> Last <b>Evans</b>  |  |   |                       |   |  |   |  |  |                        |     |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>World War I</b>  |  |                     |                       |  |  | 16b. SOCIAL SECURITY NO.<br><b>4100</b>   |  |   |                       |   |  | 17. INFORMANT<br><b>Nellie H. Gorman - 208 Rodgers Forge</b>                                    |  |  |                        |     |  | ADDRESS<br><b>208 Rodgers Forge</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriohypertension</b>                            |  |                     |                       |  |  |   |  |   |                       |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2+ yrs</b>                  |  |  |                        |     |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)   |  |                     |                       |  |  |   |  |   |                       |   |  |   |  |  |                        |     |  |                                     |  |
| 19a. DATE OF OPERATION   |  |                     |                       |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                       |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |                        |     |  |                                     |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                     |                       | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                       |   |  |   |  |  |                        |     |  |                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                     |                       | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                       |   |  |   |  |  |                        |     |  |                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |                       |  |  |   |  |   |                       |   |  |   |  |  |                        |     |  |                                     |  |
| ACTUAL SIGNATURE<br><b>Charles T. Donnell</b>  |  |                     |                       |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |                       |   |  | 22b. DATE SIGNED<br><b>4/8/69</b>   |  |  |                        |     |  |                                     |  |
| EXAMINER'S NAME (Type)   |  |                     |                       |  |  | ADDRESS (Street, city, town, or county)   |  |   |                       |   |  |   |  |  |                        |     |  |                                     |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |  |                     |                       | 23b. DATE<br><b>4/11/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>David Ridge Cem.</b>   |  |   |                       | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Md.</b> |  |   |  |  |                        |     |  |                                     |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Tichner-Sons</b>   |  |                     |                       |  |  | ADDRESS<br><b>Balto, Md.</b>  |  |   |                       | 25a. BY REGISTRAR<br><b>APR 10 1969</b>                                 |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles T. Donnell</b>    |                        |     |  |                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |                                       |   |   |  |  |                                |  |
|---|--|---|---|---|---------------------------------------|---|---|--|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |                                       |   |   |  |  |                                |  |
| 05045   |  |   |   |   |                                       |   |   |  |  |                                |  |
| CERTIFICATE OF DEATH  |  |   |   |   |                                       |   |   |  |  |                                |  |
| 05037   |  |   |   |   |                                       |   |   |  |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print) John  |  |   | First Middle Lost<br>D. Gorman  |   |                                       | 2a. DATE OF DEATH<br>Month Day Year<br>April 16 1969  |   |  | 2b. HOUR<br>8:45 PM                          |                                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>3/4/1886  |                                       | 6. AGE (In years<br>last birthday)<br>85 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Baltimore Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Stella Maris Hospice |   |                                       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>R.R. Conductor                    |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY         |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.  |  |   | 13b. COUNTY Baltimore   |   | 13c. CITY OR TOWN Baltimore           |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2515 Guilford Ave. |                                |  |
| 14. FATHER'S NAME<br>Michael  |  |   | First Middle Lost<br>Gorman   |   |                                       | 15. MOTHER'S MAIDEN NAME<br>Mary Devan  |   |  | First Middle Lost                            |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No (or unknown) No   |  |   | 16b. SOCIAL SECURITY NO.<br>717-07-8926   |   | 17. INFORMANT<br>Stella Maris Hospice |   |   | Address<br>Towson, Md. 21204   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident -</u><br><u>4369</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr -</u><br><u>Yrs -</u> |  |   |   |   |                                       |   |   |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)<br><u>Chronic bronchitis + emphysema -</u><br><u>Yrs -</u>   |  |   |   |   |                                       |   |   |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                       |   |   |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                       |   |   |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1968, 19__, to April, 1969, that (I) (we) last saw the deceased alive on 4-13-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                                       |   |   |  |  |                                |  |
| 22b. SIGNATURE<br>E. Lee Robbins  |  |   |   | DEGREE  |                                       | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/16/69.   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>E. Lee Robbins MD   |  |   |   | 22e. ADDRESS<br>812 Mockingbird Lane  |                                       |   |   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/19/69.   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery  |                                       |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214  |  |   |   |   |                                       | 25a. REC'D BY REGISTRAR<br>DATE APR 18 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]                    |  |                                |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 05046   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 05038  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last   |  |
| William   |  | L.   |  | Gover   |  |  |  |
| 2. DATE OF DEATH  |  | Month  |  | Day   |  | Year   |  |
| April 10, 1969  |  | 10   |  | 10  |  | 1969   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)  |  |
| Male  |  | White  |  | April 3, 1912   |  | 57 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Maryland  |  | USA  |  |   |  | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson  |  | St. Joseph Hospital  |  | Unemployed Labor  |  | Balto. Co.   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland  |  | Baltimore  |  | Lutherville   |  | 516 W. Seminary Ave. 21093   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  |
| Walter  |  | Virgie Virginia Gover  |  | No  |  | 220-03-3114  |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| Mildred A. Gover, Same as # 13  |  | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent Massive Gastrointestinal Bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 8</u> , 19 <u>69</u> , to <u>April 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <u>Hector L. Feliciano M.D.</u> DEGREE  |  | 22c. DATE SIGNED <u>4-10-69</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>HECTOR L. FELICIANO, M.D.</u>   |  | 22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  |
|   |  |  |  | BURIAL  |  | Apr. 14, 1969  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  | 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  |
| Poplar Grove Cemetery   |  | Baltimore County, Maryland   |  | Wm. Cook-Brooks Towson, 1050 York Road  |  | APR 14 1969  |  |
| Towson, Maryland 21204  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>M. L. Dodge</u>  |  |

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OFFICE OF THE ATTORNEY GENERAL, NEW YORK

CERTIFICATE OF DEATH

State of New York

County of New York

City of New York

Ward of New York

Block of New York

Lot of New York

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Date

Time of Death

Cause of Death

Place of Death

Signature of Physician

Signature of Registrar

Date

Place of Burial

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

Place of Interment

Signature of Minister

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

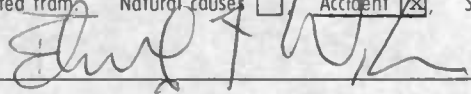
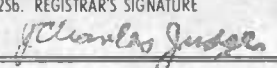
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05047

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05039

|   |  |                         |  |                                      |  |  |  |                                |   |                                |   |  |
|---|--|-------------------------|--|--------------------------------------|--|--|--|--------------------------------|---|--------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>LEON</b>   |  |                         | First Middle Last  |                                      |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month <b>27</b> Day <b>19</b> Year <b>69</b>  |  |                                | 2b. HOUR <b>1:30</b> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>                             |                                |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>9-21-1928</b> |  | 6. AGE (in years last birthday)<br><b>40</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |                                | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |                                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTO. CO. GEN. HOSP.</b> |                                      |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PHARMACIST</b>   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRUG STORE</b>  |                                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |                         | 13b. COUNTY <b>Balto.</b>  |                                      |  | 13c. CITY OR TOWN  |  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |                                | 13e. STREET AND NUMBER<br><b>2501 Hall Circle</b> |  |
| 14. FATHER'S NAME<br><b>ISADORE</b>   |  |                         | First Middle Last  |                                      |  | 15. MOTHER'S MAIDEN NAME<br><b>SARAH</b>   |  |                                | First Middle Last<br><b>KAPLAN</b>  |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |                         | (If yes give war or dates of service)  |                                      |  | 16b. SOCIAL SECURITY NO.   |  |                                | 17. INFORMANT<br><b>MRS. ANITA GREENBERG</b>  |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Injuries</b><br><b>8120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |                                      |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                         |  |                                      |  |  |  |                                |   |                                |   |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                      |  |  |  |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>7:38</b> P.M. <b>4-26- 19 69</b>                        |                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subj. driver in auto-auto head-on collision</b>  |  |                                |   |                                |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Street</b>                |                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Beltway &amp; Liberty Rd. Balto. M.D.</b>   |  |                                |   |                                |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |                                      |  |  |  |                                |   |                                |   |  |
| ACTUAL SIGNATURE<br>   |  |                         | EXAMINER'S NAME (Type)<br><b>Edward F. Wilson, M.D.</b>  |                                      |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |                                | 22b. DATE SIGNED<br><b>4/27/69</b>  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                         | 23b. DATE<br><b>4-28-69</b>  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>  |  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>REISTERSTOWN, MARYLAND</b>                                      |                                |   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  |                         |  |                                      |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 30 1969</b>   |  |                                | 25b. REGISTRAR'S SIGNATURE<br> |                                |   |  |

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |   |   |   |                  |
|---|--|---|--|--|---|---|---|---|------------------|
| 05048   |  |   |  |  |   |   |   |   |                  |
| CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |   |                  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last  |  |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |                  |
| Brenda Marie GRIFFITHS  |  |   |  |  |   | Month 4 Day 15 Year 69  |   | 12:00 noon  |                  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)   |   | IF UNDER 1 YEAR   |                  |
| Female  |  | White   |  | Dec. 6, 1954   |   | 14 YRS.   |   | MONTHS DAYS HOURS MIN   |                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   | Md.   |                  |
| Maryland  |  | U.S.A.  |  |  |   | Baltimore   |   |   |                  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |
| Owings Mills  |  |   | Rosewood State Hospital  |  |   | none  |   | none  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |   | 13b. COUNTY  |  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                  |
| Maryland  |  |   |  |  |   | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |  |   | 13e. STREET AND NUMBER  |   |   |                  |
| First Middle Last   |  |   | First Middle Last  |  |   | 4555 Shamrock Ave.,   |   |   |                  |
| Stephen - GRIFFITHS   |  |   | Audrey Helen McGE  |  |   |   |   |   |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |   | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT Address   |   |   |                  |
| no  |  |   | -----  |  |   | Rosewood Records, Owings Mills, Md. 21117   |   |   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |   |   |   | 2 -hours  |                  |
| IMMEDIATE CAUSE (a) Aspiration  |  |   |  |  |   |   |   |   |                  |
| 7439 DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |   |   |   |                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |   |   |   | since birth   |                  |
| (b) Spasticity - brain damage   |  |   |  |  |   |   |   |   |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |   |   |   |   |                  |
| (c)   |  |   |  |  |   |   |   |   |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |   |   |   |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |                  |
|   |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |   |   |   |   |                  |
|   |  | HOUR A.M. Month Day Year P.M.   |  |  |   |   |   |   |                  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |   |                  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |   |  |  |   |   |   |   |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/16, 19 55, to 4/15/69, 19, that (I) (we) last saw the deceased alive on 4/15/ 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |   |   |                  |
| 22b. SIGNATURE  |  |   |  |  | DEGREE  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED |
| Esteban V. Diaz M.D.  |  |   |  |  |   |   |   |   | 4/15/69          |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  |  | 22e. ADDRESS  |   |   |   |                  |
| Esteban Diaz, M.D.  |  |   |  |  | Rosewood State Hospital, Owings Mills, Md.                          |   |   |   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |   |   |                  |
| BURIAL  |  | 4/17/69.  |  | Holy REDEEMER Cem.   |   | Baltimore, Md.  |   |   |                  |
| 24. FUNERAL DIRECTOR  |  |   |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |   |                  |
| LEONARD J. RUCK, Inc. Balto. 14, Md.  |  |   |  |  | DATE APR 17 1969  |   | Charles J. Jones  |   |                  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|----------------------------------|--|--|------------|--|--|---------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 05049   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 05041   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Harry   |  |  | Middle<br>S   |  |  | Last<br>Grimes  |  |  | 2a. DATE OF DEATH<br>Month<br>4                 |  |  | Day<br>11                        |  |  | Year<br>69 |  |  | 2b. HOUR<br>2:55 AM |  |  |
| 3. SEX<br>male  |  |  | 4. RACE<br>white   |  |  | 5. DATE OF BIRTH<br>2-1-27  |  |  | 6. AGE (In years<br>lost birthday)<br>82 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS               |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN |  |  |            |  |  |                     |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>U.S.A.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Co.   |  |  | Md.   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Baltimore Co. General |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during last year)<br>Retired  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Pikesville   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>830 Milford Mill Rd.  |  |  |                                  |  |  |            |  |  |                     |  |  |
| 14. FATHER'S NAME<br>George W. Grimes   |  |  | First<br>Middle<br>Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>Mabel R. Johnson  |  |  | First<br>Middle<br>Last   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/><br>(If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>215-09-3555  |  |  | 17. INFORMANT<br>Mabel R. Grimes - Same   |  |  | Address   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probably cardiac arrhythmias</u><br><u>4123</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) <u>atherosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |                                  |  |  |            |  |  |                     |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 22b. SIGNATURE<br>S. Chaiyavet  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br>4-11-69   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>J. Oster / Chaiyavet   |  |  | 22e. ADDRESS<br>714 N. Broadway St.  |  |  |   |  |  |   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>4-14-69   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |
| 24. FUNERAL DIRECTOR<br>Armacost Funeral Chapel - 4600 Liberty Highway  |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br>APR 15 1969  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |   |  |  |                                  |  |  |            |  |  |                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05050

CERTIFICATE OF DEATH

05042

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>IRENE R. GROTZINGER</b>   |  | 2a. DATE OF DEATH<br><b>APRIL</b> Month <b>13</b> , 19 <b>69</b> Year                                     |  | 2b. HOUR<br><b>9:15</b> A M   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br><b>September 22, 1894</b>   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>400 S. Rolling Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  |
| 14. FATHER'S NAME<br><b>John Bezold</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Theresa Peters</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. William Grotzinger</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br><b>4100</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPERTENSIVE AND ART. SCL. C.V. DIS.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>INFLUENZA SUSPECTED</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>10 + YRS</b><br><b>1 WK</b>          |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)                             |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 2, 1958</b> , to <b>APR 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>APR 12, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John N. Snyder M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/14/69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN N. SNYDER, M.D.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 16, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Earling Funeral Estate</b>  |  | 25a. BY REGISTERAR<br><b>APR 16 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>  |  | 23e. ADDRESS<br><b>736 Edmondson Ave.</b>   |  | 23f. ADDRESS<br><b>Catonsville, Md. 21228</b>   |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR

LAND OFFICE

WASHINGTON, D. C.

June 1, 1900

TO THE SECRETARY OF THE INTERIOR

FROM THE LAND OFFICE

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UNITED STATES DEPARTMENT OF THE INTERIOR

LAND OFFICE

WASHINGTON, D. C.

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UNITED STATES DEPARTMENT OF THE INTERIOR

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FROM THE LAND OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 05051   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05043  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | Hour Min.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| John E. Guetler   |  |  |  |  |  |  |  |  |  | 4 4 69   |  |  |  |  |  |  |  |  |  | 12:15  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | 8/22/1895  |  |  |  |  |  |  |  |  |  | 73 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Randallstown  |  |  |  |  |  |  |  |  |  | Balto. Co. Gen. Sheet Metal Worker U.S. Govt.                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | Balto.   |  |  |  |  |  |  |  |  |  | Randallstown   |  |  |  |  |  |  |  |  |  | NO   |  |  |  |  |  |  |  |  |  | 10913 Steffeny Road         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| George Guetler  |  |  |  |  |  |  |  |  |  | Julia Geidt  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Yes   |  |  |  |  |  |  |  |  |  | WW I   |  |  |  |  |  |  |  |  |  | 220-44-8683  |  |  |  |  |  |  |  |  |  | BCGH records, Randallstown, Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 hrs   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | many years   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4100  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | years  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | many years   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | years  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
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| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
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| 22a. I certify that (I) (this hospital) attended the deceased from Nov 28, 1959, to April 19, 1969, that (I) (we) last saw the deceased alive on March 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| MARVIN H. DAVIS, M.D.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| MARVIN H. DAVIS   |  |  |  |  |  |  |  |  |  | 6512 LIBERTY RD Balto 21207  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | April 8, 69  |  |  |  |  |  |  |  |  |  | Woodlawn Cemetery  |  |  |  |  |  |  |  |  |  | Woodlawn Baltimore County Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Loring Byers Chapel 8728 Liberty Rd. Randallstown   |  |  |  |  |  |  |  |  |  | APR 7 1969   |  |  |  |  |  |  |  |  |  | J. Charles Judge   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |   |  |   |  |                                |  |
|--|--|--|--|---|--|--|---|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |   |  |   |  |                                |  |
| Items 6, 7, & 8 Film 412 5/6/69 kk CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>WILLIAM T HALE</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>4 27 69</b>  |   |  | 2b. HOUR<br><b>12:45</b>                            |  |                                |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br><b>1/28/1903</b>  |  |  | 6. AGE (In years last birthday)<br><b>65/66</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO. MED. CENT.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Mechanic</b>                             |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>    |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3908 Ridgcroft Rd.</b> |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br><b>Horace Hale</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Haynie</b>   |   |  |  |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212 07 8788A</b>  |   | 17. INFORMANT Address<br><b>Mrs. Vera G. Hale 3908 Ridgcroft Rd.</b> |  |   |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |   |  |   |  |                                |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |   |  |   |  |                                |  |
| IMMEDIATE CAUSE (a) <b>CA OF LARYNX</b>  |  |  |  |   |  |  |   |  |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |  |   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |   |  |   |  |                                |  |
| (b) <b>1619</b>  |  |  |  |   |  |  |   |  |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |  |   |  |                                |  |
| (c)  |  |  |  |   |  |  |   |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |   |  |                                |  |
| 22a. I certify that (I) <del>(his husband)</del> attended the deceased from <b>1/18</b> , 19 <b>69</b> , to <b>4/27</b> , 19 <b>69</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>4/26</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(did not)</del> view the body after death. |  |  |  |   |  |  |   |  |   |  |                                |  |
| 22b. SIGNATURE<br><b>Bahram Eslami</b>   |  |  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/27/69</b>                                   |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>BAHRAM ESLAMI</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST.</b>   |   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-29-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Maryland</b>                 |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>William E. Johnson 8521 Loch Raven Blvd. 21204</b>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 1 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                     |   |  |                                |  |

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| 1. DECEASED NAME<br>(Type or print)   |  | First  | Middle | Last  | 2a. DATE OF DEATH             |  | 2b. HOUR |  |
|---|--|--|--------|---|-------------------------------|--|----------|--|
| GLENN   |  |  | -      | HALFORD   | APRIL Month 12, Day 1969 Year |  | 2:15 PM  |  |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH  |                               | 6. AGE (In years last birthday)  |          | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |
| MALE  |  | NEGRO  |        | 1/29/1900   |                               | 69 YRS.  |          |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. COUNTY OF DEATH   |          |  |
| SOUTH CAROLINA  |  | U.S.A.   |        |   |                               | BALTIMORE Md.  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                               | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |
| FORT HOWARD   |  | VETERANS ADMIN. HOSPITAL   |        | MOTOR OPERATOR  |                               | Steel  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                   |
| MARYLAND  |  |  |        | BALTIMORE   |                               |  |          | 3016 BAKER STREET                        |
| 14. FATHER'S NAME   |  | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME      |  | First    | Middle Last                              |
| BEN   |  | -  | -      | HALFORD   | HAGGER                        |  | -        | JOHNSON                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT Address   |                               |  |          |  |
| YES   |  | WWI  |        | 218 05 2169 CLINICAL RECORDS, VAH, FT. HOWARD, MD.  |                               |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PLEURAL EFFUSION AND PNEUMONIA</u><br><u>151.9</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GASTRIC CA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 WEEKS</u><br><u>8 - 12 MONTHS</u> |  |  |        |   |                               |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |  |        |   |                               |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                               |  |          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                               |  |          |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>DEC 28</u> , 19 <u>68</u> , to <u>APR 12</u> , 19 <u>69</u> , that <del>he</del> (we) last saw the deceased alive on <u>APR 12</u> , 19 <u>69</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not see</del> view the body after death.   |  |  |        |   |                               |  |          |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |        | 22d. PHYSICIAN'S NAME (Type)  |                               |  |          |  |
| <i>James K. Davis, M.D.</i>   |  | 4/12/69  |        | JAMES K. DAVIS, M.D.  |                               |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION (City or Town) (County) (State)  |          |  |
| BURIAL  |  | 4-17-69  |        | BALTO. NATIONAL CEMETERY  |                               | BALTIMORE, MD.   |          |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE  |                               |  |          |  |
| NUTTER FUNERAL HOME   |  | DATE APR 16 1969   |        | <i>Charles Judge</i>  |                               |  |          |  |

## APPENDIX

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• **DRUGS**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |                                       |   |  |  |   |  |  |
|---|--|--|---|--|---------------------------------------|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |                                       |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |                                       |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <u>First</u> <u>adahl</u> <u>Middle</u> <u>S</u> <u>Last</u> <u>Hall</u>  |  |  |   |  |                                       | 2a. DATE OF DEATH<br><u>4</u> <del>xx</del> <u>6</u> Month <u>7</u> Day <u>69</u> Year  |  |  | 2b. HOUR<br><u>530</u> <u>M</u>                         |  |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>white</u>  |   | 5. DATE OF BIRTH<br><u>3-28-88</u>   |                                       | 6. AGE (In years last birthday)<br><u>81</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>md.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. COUNTY OF DEATH<br><u>Baltimore</u> Md.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore 28</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Caton Lodge NW</u> |  |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>SALES</u>                         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Dept. Store</u> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>md.</u>   |  |  | 13b. COUNTY<br><u>BALTO</u>   |  | 13c. CITY OR TOWN<br><u>Baltimore</u> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>1015 Adcock Road</u>       |  |  |
| 14. FATHER'S NAME<br><u>John School</u>   |  |  | 15. MOTHER'S MAIDEN NAME<br><u>Louise</u>   |  |                                       | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><u>Yes, no, or unknown</u>                 |  |  | 17. INFORMANT<br><u>J. Hansen Rn</u> Address            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br><u>471X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Influenza-like illness</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |                                       |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>4 days</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Generalized arteriosclerosis - Severe Chronic Brain Syndrome</u>  |  |  |   |  |                                       |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                       |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                       |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-24-1967</u> , to <u>4-xx-7-1969</u> , that (I) (we) last saw the deceased alive on <u>4-xx-7-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                       |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Cesar Valle Cervero M.D.</u>   |  |  |   |  |                                       | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>xx-7-69</u>                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>CESAR VALLE CAVERO M.D.</u>  |  |  |   |  |                                       | 22e. ADDRESS  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>4-9-69</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>mt Olivet</u>   |                                       | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE md</u>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Wm Cook-Brooks-Touson</u>  |  | ADDRESS<br><u>1450 York Road</u>   |   | 25a. REC'D BY REGISTRAR<br><u>APR 11 1969</u>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. [unclear]</u>   |  |  |   |  |  |

82022

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

OFFICE OF THE SECRETARY

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APR 11 1994



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |  |   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| 05055  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                   |  |  |   | 05047   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Dorothy Phillips Hall   |  |   |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 28 1969  |  | 2b. HOUR<br>5:10 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>6-23-1898  |   | 6. AGE (in years last birthday)<br>70 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Lutherville   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Co.   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>College Manor |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>School Teacher (Ret.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>School   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Harford  |  | 13c. CITY OR TOWN<br>Bel Air   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>Medical Hall Farm                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Sidney Hall (D)  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Anne F. Crampton (D)                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No  |   |   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br>Anne I. Hall, Medical Hall Farm, Bel Air, Md                      |  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>degenerative brain disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arterio sclerosis</u>                             |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 yrs.<br>3 yrs.<br>5 yrs. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 5, 1966, to April 28, 1969, that (I) (we) last saw the deceased alive on April 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Palmer P. Williams M.D.  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>April 28, 1969                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>PALMER P. WILLIAMS   |  |   |  |  | 22e. ADDRESS<br>Carnegie Mills, Md.   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>1 May 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Spesutia Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Perryman, Maryland                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>Tarring Funeral Home<br>Aberdeen, Md. 21001  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>MAY 2 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |  |  |

05055

DEPARTMENT OF STATE

1954

|          |                              |
|----------|------------------------------|
| TO:      | SECRETARY OF STATE           |
| FROM:    | AMERICAN EMBASSY, WASHINGTON |
| SUBJECT: | RE: [illegible]              |
| DATE:    | 10/15/54                     |
| TIME:    | 10:00 AM                     |
| BY:      | [illegible]                  |
| THROUGH: | [illegible]                  |
| REMARKS: | [illegible text block]       |

10/15/54  
AMERICAN EMBASSY, WASHINGTON  
10:00 AM  
[illegible signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. ~~See~~ Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

05056

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05048

|  |                         |   |   |  |                                   |   |  |   |  |
|--|-------------------------|---|---|--|-----------------------------------|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <u>Leslie Grant Harrison</u><br><u>Alva-Cletus-H</u>   |                         |   |   | 2a. DATE KNOWN OF ESTI-DEATH MATED <u>April 10 1969</u>  |                                   |   |  | 2b. HOUR <u>1:30 P</u>  |  |
| 3. SEX<br><u>Male</u>  | 4. RACE<br><u>White</u> | 5. DATE OF BIRTH<br><u>Dec 12, 1902</u>   | 6. AGE (in years last birthday)<br><u>66</u> YRS. | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  | IF UNDER 24 HRS.<br>HOURS<br>MIN. | 2c. DATE PRONOUNCED DEAD<br><u>April 10 1969</u>  |  | 2d. HOUR<br><u>1:30 P</u>   |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                   | 9. COUNTY OF DEATH<br><u>Baltimore</u>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Country Club of Maryland</u> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Groundskeeper</u>  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Country Club</u>  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><u>Baltimore Md.</u>  |                         | 13b. COUNTY<br><u>Baltimore</u>   |   | 13c. CITY OR TOWN<br><u>Towson</u>   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>292 Ridge Avenue</u>                                   |  |
| 14. FATHER'S NAME First Middle Last<br><u>William Harrison</u>   |                         |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Florence Wells</u>  |                                   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                         | 16b. SOCIAL SECURITY NO.<br><u>None</u>   |   | 17. INFORMANT<br><u>Agnes S. Harrison, 252 Ridge Ave., Towson, Md.</u>   |                                   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109 Coronary Occlusion Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |   |  |                                   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |   |   |  |                                   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |  |                                   |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Charles J. Connolly</u><br>EXAMINER'S NAME (Type)   |                         | M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                                   | 22b. DATE SIGNED<br><u>4/10/69</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                         | 23b. DATE<br><u>April 14, 1969</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Memorial Cemetery Parkville, Maryland</u>  |                                   | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |                         |   |   | ADDRESS  |                                   | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 15 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Connolly</u>                            |  |

02020

Leslie (first position)  
\_\_\_\_\_

1911, Dec 1, 1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
|--|--|--|--|--|---|--|---------------------------------|--|-----------------|--|------------------|--------|--|------|--|
| 05057  |  |  |  |  | CERTIFICATE OF DEATH  |  |                                 |  |                 | 05049  |                  |        |  |      |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle   |   | Last   |                                 | 2a. DATE OF DEATH  |                 |  | 2b. HOUR         |        |  |      |  |
| Eleanor  |  | Bentley  |  | Hart   |   | Month 4 Day 17 Year 69   |                                 |  | 5:24 P M        |  |                  |        |  |      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |        |  |      |  |
| female   |  | White  |  | 10-3-1894  |   |  | 74 YRS.                         |  | MONTHS DAYS     |  | HOURS MIN        |        |  |      |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH              |  |                 |  |                  |        |  |      |  |
| Baltimore  |  | U.S.A.   |  |  |   |  | Baltimore Md.                   |  |                 |  |                  |        |  |      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                 |  |                  |        |  |      |  |
| Baltimore  |  | St. Joseph Hospital  |  |  | homemaker   |  |                                 |  |                 |  |                  |        |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                 | 13e. STREET AND NUMBER   |                 |  |                  |        |  |      |  |
| Maryland   |  | Balto  |  | Balto  |   |  |                                 | 346 E. Belvedere Ave.  |                 |  |                  |        |  |      |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   |   | Last   |                                 | 15. MOTHER'S MAIDEN NAME   |                 | First  |                  | Middle |  | Last |  |
| Lawrence   |  | E.   |  | Parks  |   |  |                                 | Mary   |                 |  |                  | German |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                 |  |                 |  |                  |        |  |      |  |
| No   |  |  |  | 22-427-694   |   | Mr. John B. Hart, 37 Orthoridge Road   |                                 |  |                 |  |                  |        |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |                                 |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |        |  |      |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |   |  |                                 |  |                 | Cardiogenic shock                            |                  |        |  |      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |   |  |                                 |  |                 | Acute Myocardial Infarction                  |                  |        |  |      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| (c)  |  |  |  |  |   |  |                                 |  |                 | Complete Heart Block                         |                  |        |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| Diabetes Mellitus  |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY?—   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                 |  |                  |        |  |      |  |
| 4-17-69  |  | Complete Heart Block   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                 |  |                 |  |                  |        |  |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                 |  |                 |  |                  |        |  |      |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | Street or R.F.D. No. City or Town County State   |   |  |                                 |  |                 |  |                  |        |  |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-15-69, 19__, to 4-17-69, 19__, that (I) (we) last saw the deceased alive on 4-17-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS.  |   | MED. DIRECTOR  |                                 | STAFF PHYS.  |                 | 22c. DATE SIGNED                             |                  |        |  |      |  |
| John J. Messina M.D.   |  |  |  |  |   | <input checked="" type="checkbox"/>  |                                 | <input type="checkbox"/>   |                 | 4-17-69                                      |                  |        |  |      |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| John J. Messina, M.D.  |  | 7620 York Road, Baltimore, Md. 21204   |  |  |   |  |                                 |  |                 |  |                  |        |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)   |                                 | (County)   |                 | (State)                                      |                  |        |  |      |  |
| Burial   |  | 4/21/69  |  | Prospect Hill  |   | Towson, Balto. Co.,  |                                 |  |                 | Md.  |                  |        |  |      |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                                 |  |                 |  |                  |        |  |      |  |
| H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.   |  | APR 18 1969  |  | Charles Jones  |   |  |                                 |  |                 |  |                  |        |  |      |  |



5320

10-1-10

1852



## CERTIFICATE OF DEATH

05050

1. NAME OF DECEASED  
(Type or Print)

CECELIA HARTZ

2. DATE AND HOUR OF DEATH

APRIL 28, 1969 12:30 P, M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MILFORD MANOR NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

FLEETWOOD APTS.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

LATVIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BENJAMIN FOX

14. MOTHER'S MAIDEN NAME

SARAH ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

AMERICANA LANDMARK APTS. MR. STANLEY HARTZ, APT. 16, 2907 FALLSTAFF RD. #9

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C. V. A.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

A S H D

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

3 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL

22. I certify that (I) (this hospital) attended the deceased from 4/22 to 4/28 1969 that (I) (we) last saw the deceased alive on 4/22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Israel Zinberg M.D.

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

4/28/69

23C. PHYSICIAN'S NAME (Type)

ISRAEL ZINBERG

23D. ADDRESS

4001 W. NORTHERN PKWY.

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-30-69

24C. NAME OF CEMETERY OR CREMATORY

MIKRO KODESH-BETH ISRAEL

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

VR A1 45M -

25A. DATE REC'D BY HEALTH DEPT.

MAY 2 1969

25B. NAME OF REGISTRAR

John A. Jones

25C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

TION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05059

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05051

|   |  |                         |  |  |  |  |  |  |  |   |  |  |  |
|---|--|-------------------------|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>HUBERT ALLEN</i> <sup>First</sup> <i>HAWES</i> <sup>Last</sup>   |  |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>APR</i> Day <i>4</i> Year <i>1969</i> |  |  |  | 2b. HOUR <i>8:50</i> AM  |  |   |  |  |  |
| 3. SEX <i>Male</i>  |  | 4. RACE <i>W.</i>       |  | 5. DATE OF BIRTH <i>Aug 30, 1905</i>   |  | 6. AGE (In years last birthday) <i>63</i> YRS. |  | 7c. DATE PRONOUNCED DEAD Month <i>Apr</i> Day <i>4</i> Year <i>1969</i>  |  | 2d. HOUR <i>8:50</i> AM   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>W. VA. USA</i>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.            |  |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i>   |  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8508 Fieldway Dr.</i>      |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>accountant</i>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>E.C. R.R.</i> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  |                         |  | 13b. COUNTY <i>Balt. Randallstown</i>  |  |  |  | 13c. CITY OR TOWN <i>YES</i> <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. INSIDE CITY LIMITS? <i>YES</i> <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME First <i>Jesse</i> Middle <i>Hawes</i> Last <i>Mina</i>   |  |                         |  | 15. MOTHER'S MAIDEN NAME First <i>Vaughn</i> Middle <i>Vaughn</i> Last <i>Vaughn</i>                       |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>   |  |                         |  | 16b. SOCIAL SECURITY NO. <i>718-16-7119</i>  |  |  |  | 17. INFORMANT ADDRESS <i>Mr Idris Barton Hawes. (same.)</i>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |                         |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i>   |  |                         |  |  |  |  |  |  |  | <i>3 mt.</i>  |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <i>4109</i>   |  |                         |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>4109</i>  |  |                         |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ulcerative colitis.</i>   |  |                         |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <i>1963</i>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>ulcerative colitis</i>                                |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>none</i>   |  |                         |  | 21b. TIME OF INJURY Month, Day, Year <i>none</i> HOUR A.M. <i>none</i> P.M. <i>none</i>                    |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>none</i>  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>none</i>                   |  |  |  | 21f. LOCATION Street or R.F.D. No. <i>none</i> City or Town <i>none</i> County <i>none</i> State <i>none</i>   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <i>D. D. Caples</i>  |  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <i>4/6/69</i>   |  |   |  |  |  |
| EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>  |  |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |   |  |  |  |
|   |  |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |  |  |
|   |  |                         |  | ADDRESS (Street, city, town, or county)  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 23b. DATE <i>4-9-69</i> |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Hunington W. Va Cem.</i>   |  |  |  | 23d. LOCATION (City or Town) <i>Hunington</i> (County) <i>W. VA.</i> (State)   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <i>Loring Byers Chapel 8728 Liberty Rd</i>   |  |                         |  | ADDRESS <i>21135</i>   |  |  |  | 25a. REC'D BY REGISTRAR <i>APR 9 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>  |  |  |  |

CECER

• 1980 •

1940-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV. 11-68

|   |  |   |   |   |         |  |  |  |
|---|--|---|---|---|---------|--|--|--|
| 05060   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                 |   |   |         | 05052  |  |  |
| Item 13 Film 412 4/30/69 kk   |  | CERTIFICATE OF DEATH  |   |   |         |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>ELEANOR OTTENHEIMER HESS   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>APRIL 18 1969  |   |         | 2b. HOUR<br>2 P. M.  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>JULY 1, 1888  |         | 6. AGE (In years last birthday)<br>80 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>DULANEY TOWSON NURSING HOME |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE  |         | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>TOWSON   |         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br>204 Milford Mill  |  | 13f. CITY OR TOWN<br>BALTIMORE  |   | 13g. COUNTY<br>BALTIMORE  |         | 13h. STATE<br>MARYLAND   |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>ELEAZIE O. OTTENHEIMER  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>AMELIA GREENBAUM                           |   |         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>17. INFORMANT<br>MR. EDWIN OTTENHEIMER, 303-1st NAT. BANK BLDG. |   | Address |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis cv + cns disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>6+ yrs</u>   |  |   |   |   |         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |         |  |  |  |
| 19a. DATE OF OPERATION<br><u>none</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |         |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><u>none</u>                 |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |         |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/22, 1967</u> , to <u>4/18, 1969</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |         |  |  |  |
| 22b. SIGNATURE<br><u>Maurice Feldman</u>  |  | DEGREE<br>MAURICE FELDMAN   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |         | 22c. DATE SIGNED<br>4/19/69  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>MAURICE FELDMAN   |  | 22e. ADDRESS<br>6610 CROSS COUNTRY BLVD.  |   |   |         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-21-69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP   |         | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                         |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |   |   | 25a. REC'D BY REGISTRAR<br>APR 23 1969  |         | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |

05070

RECEIVED 11 APR 1952

APR 1 1952

WHITE

MR

SALES B. ...

TO ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |  |  |
| 05061   |  |  |   |   |  |  |  |  |  |
| 05053   |  |  |   |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br><i>Wilmer P. Hesse</i>   |  |  | 2a. DATE OF DEATH<br>4 Month 17 Day 69 Year                     |   |  |  | 2b. HOUR<br>5:50 A.M.  |  |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>W</i>  |   | 5. DATE OF BIRTH<br><i>7/26/89</i>  |  | 6. AGE (In years lost birthday)<br><i>79</i> YRS.                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore 21228</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Summit Nursing Home</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>md.</i>   |  | 13b. CITY OR TOWN<br><i>BA Ho.</i>   |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><i>118 Allendale St-29</i>                   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><i>John Hesse</i>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Barbara V.</i> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>216-10-4458</i>   |   | 17. INFORMANT Address<br><i>Mrs. Hilda Schaeffer, 118 N. Allendale St.</i>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia Terminal</i><br><i>4330</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Cerebral Thrombus General Paralysis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Cerebral Thrombus Left Side Arterio Sclerosis</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 days</i><br><i>3/1/69</i><br><i>1954</i> |  |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Hypertensive Cardio Vascular Disease</i>   |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1954</i> , 19 <i>69</i> , to <i>4/17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Eliot W. Johnson</i> M.D.  |  | DEGREE   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  | 22c. DATE SIGNED<br><i>4/17/69</i>                                     |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Dr. E. W. Johnson</i>  |  | 22e. ADDRESS<br><i>3437 Frederick Ave Baltimore Md 21229</i>   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>4/19/69</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i> |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Witzke, 4101 Edmondson Ave., 21229</i>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 17 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                     |  |  |  |

07061

CERTIFICATE OF DEATH

SWEDEN - DEATH RECORDS - 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05062

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05054

|   |  |  |                     |   |   |   |                          |   |                                   |
|---|--|--|---------------------|---|---|---|--------------------------|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  | First <u>Maria</u>   | Middle <u>Maria</u> | Last <u>Hiewsky</u>   | 2a. DATE OF DEATH<br>Month <u>April</u> Day <u>3</u> Year <u>1969</u> |   | 2b. HOUR<br><u>5 A M</u> |   |                                   |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Cauc</u>   |                     | 5. DATE OF BIRTH<br><u>17 Aug 1919</u>  |   | 6. AGE (In years last birthday)<br><u>50</u> YRS.   |                          | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Russia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><u>Baltimore</u>  |                          |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><u>Catonsville</u><br><u>Baltimore, Maryland</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Shangra-la Nursing Home</u> |                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Health - Aid</u>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>City of Baltimore</u>                                   |                          |   |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>Baltimore</u>  |                     | 13c. CITY OR TOWN<br><u>Baltimore</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          | 13e. STREET AND NUMBER<br><u>2039 E Lombard Street</u>  |                                   |
| 14. FATHER'S NAME<br>First <u>Victor</u> Middle <u>-</u> Last <u>Garais</u>   |  | 15. MOTHER'S MAIDEN NAME<br>First <u>Varvara</u> Middle <u>-</u> Last <u>Macht</u>                             |                     |   |   |   |                          |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>097-28-1451</u>   |                     | 17. INFORMANT<br>Address <u>Wolodimir Hiewsky 4723 Uncouped Rd</u>  |   |   |                          |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure - Hypotension</u><br><u>1929</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Increased Intracranial Pressure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Glioblastoma</u> |  |  |                     |   |   |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mths</u><br><u>10 mths</u><br><u>10 mths</u> |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>NONE</u>  |  |  |                     |   |   |   |                          |   |                                   |
| 19a. DATE OF OPERATION<br><u>June 1968</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Glioblastoma</u>  |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                          |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>  |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                          |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                     | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |                          |   |                                   |
| 22a. I certify that (U) (this hospital) attended the deceased from <u>21 Jan</u> , 19 <u>69</u> , to <u>3 April</u> , 19 <u>69</u> , that (U) (we) last saw the deceased alive on <u>21 March</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (U) (we) (did) (did not) view the body after death.   |  |  |                     |   |   |   |                          |   |                                   |
| 22b. SIGNATURE<br><u>Richard R. Stephenson M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |                     |   |   |   |                          | 22c. DATE SIGNED<br><u>3 April 1969</u>   |                                   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Richard R. Stephenson M.D.</u>   |  |  |                     | 22e. ADDRESS<br><u>1302 Crofton Road, Balt. Md 21212</u>  |   |   |                          |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>4/7/69</u>   |                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Andrew's</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u>                     |                          |   |                                   |
| 24. FUNERAL DIRECTOR<br><u>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE.</u>  |  |  |                     | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 7 1969</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                          |   |                                   |

05062

APR 1 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05055

|  |         |                              |  |   |                   |   |  |                                 |   |          |  |
|--|---------|------------------------------|--|---|-------------------|---|--|---------------------------------|---|----------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |   |                   | 2a. DATE KNOWN OF DEATH   |  |                                 |   | 2b. HOUR |  |
| AMELIA   |         |                              | HILDEBRAND   |   |                   | Month Day Year<br>April 16 1969   |  |                                 |   | 11:17    |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                   | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD        |   | 2d. HOUR |  |
| Female   | White   | Oct. 13                      | 77 YRS.  |   |                   |   |  | Month Day Year<br>April 16 1969 |   | 11:17    |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |                                 |   |          |  |
| Balto  |         | US                           |  |   |                   | Baltimore Md.   |  |                                 |   |          |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY             |          |  |
| Towson   |         |                              | Greater Balto. Medical Center  |   |                   |   |  |                                 |   |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 | 13e. STREET AND NUMBER                        |          |  |
| Md.  |         |                              | Balto.   |   | Balto.            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |                                 | 2922 E. Coldspring Lane                       |          |  |
| 14. FATHER'S NAME<br>First Middle Last   |         |                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |                   |   |  |                                 |   |          |  |
| Wm Roch  |         |                              | Katherine  |   |                   |   |  |                                 |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |   |                   | 17. INFORMANT   |  |                                 | ADDRESS                                       |          |  |
|  |         |                              |  |   |                   | Melvin O Hildebrand   |  |                                 | 219 Forrest Rd                                |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |                              |  |   |                   |   |  |                                 |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Adenocarcinoma of the uterus</u>  |         |                              |  |   |                   |   |  |                                 |   |          |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |                                 |   |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19                 |   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |                                 |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |                   | 21f. LOCATION Street or R.F.D. No.  |  |                                 | City or Town                                  |          | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |   |                   |   |  |                                 |   |          |  |
| ACTUAL SIGNATURE   |         |                              | CHIEF MEDICAL EXAMINER   |   |                   | ASSISTANT MEDICAL EXAMINER  |  |                                 | 22b. DATE SIGNED                              |          |  |
| EXAMINER'S NAME (Type)   |         |                              | Ronald N. Kornblum, M.D.   |   |                   | DEPUTY MEDICAL EXAMINER   |  |                                 | April 16, 1969                                |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |   |                   | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                 | 23d. LOCATION (City or Town) (County) (State) |          |  |
| Burial   |         |                              | 4/19/69  |   |                   | Cathwood  |  |                                 | Baltimore                                     |          |  |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |   |                   | 25a. REC'D BY REGISTRAR   |  |                                 | 25b. REGISTRAR'S SIGNATURE                    |          |  |
| Hildebrand   |         |                              | 6067 Bayford Rd  |   |                   | APR 22 1969   |  |                                 | Charles J. George                             |          |  |

02083

ADOLPH EXAMINING CERTIFICATE OF BIRTH

APR 23 1963



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05056

|  |                  |   |  |   |  |  |  |  |  |   |  |   |  |
|--|------------------|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First<br>ROSE   |  | Middle  |  | Last<br>HODGES   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year<br><input checked="" type="checkbox"/> 4/4/69 19 2:15 <sup>a</sup> M |  |   |  | 2b. HOUR  |  |
| 3. SEX<br>female   | 4. RACE<br>white | 5. DATE OF BIRTH<br>4/30/92   |  | 6. AGE (in years<br>last birthday)<br>76 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>4/4/69 2:43 <sup>a</sup> AM |  | 2d. HOUR  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Baltimore  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH<br>Baltimore  |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Benjies   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rt. 14, Box 13 |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Machine Opr. Continental Can |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                      |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |                  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET AND NUMBER<br>611 N. Potomac St.   |  |   |  |   |  |
| 14. FATHER'S NAME  |                  | First<br>Charles J. Hart  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First<br>Kate White   |  | Middle<br>Last                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |                  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>215-03-3674   |  | 17. INFORMANT<br>Benjies, Md. ADDRESS 21220<br>Milred W. Harrod, dght. Rt. 14, Box 13                                      |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>4123<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                  |   |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>   |                  |   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |  |   |  |  |  |  |  |   |  |   |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)<br>Dr. Theodore C. Patterson  |                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  | 22b. DATE SIGNED<br>4/6/69   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>4/7/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane   |                  |   |  | 25a. RECD BY REGISTRAR<br>APR 11 1969   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |  |   |  |

05064

WORLD EXHIBITION 1904

FOR SALE

WORLD EXHIBITION 1904

WORLD EXHIBITION 1904

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>CARVEL</b>  |  | Middle<br><b>HOLLAND</b>  |  | Last<br><b>HOLLAND</b>  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 27, 1969</b>                    |  | 2b. HOUR<br><b>8:30 PM</b>                                     |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGROID</b>   |  | 5. DATE OF BIRTH<br><b>9/24/27</b>  |  | 6. AGE (In years last birthday)<br><b>41</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN                                  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   |  | Md.  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOSPITAL VETERANS ADMINISTRATION</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TRUCK DRIVER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>640 MELVIN DRIVE</b>                               |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>LOUIS HOLLAND</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>LOUISE CARROLL</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES WWII</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218 19 8351</b>  |  | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA LEFT LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/2/69</b> , 19____, to <b>4/27/69</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/27/69</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |   |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>John D. Talbert, M.D.</i>  |  | DEGREE<br><b>JOHN D. TALBERT, M. D.</b>   |  | ATTENDING PHYS.<br><input type="checkbox"/>   |  | MED. DIRECTOR<br><input type="checkbox"/>   |  | STAFF PHYS.<br><input checked="" type="checkbox"/>                              |  | 22c. DATE SIGNED<br><b>4/28/69</b>                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-2-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Rice Funeral Home</b>  |  | ADDRESS<br><b>661 W. Berre Street</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. J...</i>  |  |   |  |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |                                   |
|---|--|--|--|---|--|--|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |                                   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |                                   |
| 05066   |  |  |  |   |  |  |  |  |                                   |
| 05058   |  |  |  |   |  |  |  |  |                                   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |
| Lila  |  |  | R  |   | Hollins  | April Month 23 Day 1969 Year   |  |  | 4:30 M                            |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | 7. IF UNDER 1 YEAR   |                                   |
| Female  |  | white  |  | Aug. 18, 1896   |  | 72 YRS.  |  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |                                   |
| Russell Co. Va.   |  | U.S.A.   |  |   |  | Baltimore Md.  |  |  |                                   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hampstead   |  |  | RFD 2  |   |  | Housewife  |  |  |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |                                   |
| Md  |  |  | Baltimore  |   | Hampstead  |  |  | RFD 2  |                                   |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |  | First Middle Last                 |
| Samuel Reed   |  |  |  |   |  | Sarah Duncon   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |                                   |
| NO  |  |  |  |   | 511-18-1666  |  | Mrs. Charlie Honegardner   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u><br><u>7 yrs</u> |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>April 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |                                   |
| 22b. SIGNATURE <u>W. H. Foard</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>4/24/69</u>                                      |  |                                   |
| 22d. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>  |  |  |  |   | 22e. ADDRESS <u>Manchester, Md 21102</u>   |  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |                                   |
| Burial  |  | April 26, 1969   |  | Evergreen Cemetery  |  | Finksburg, Carroll Md.   |  |  |                                   |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |
| Tipton - Eline Funeral Home Hampstead, Md.  |  |  |  |   | APR 29 1969  |  | Charles Judge  |  |                                   |



02000

OFFICE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

|                       |  |
|-----------------------|--|
| NAME OF DECEASED      |  |
| AGE                   |  |
| SEX                   |  |
| RACE                  |  |
| RELIGION              |  |
| MARRIAGE              |  |
| OCCUPATION            |  |
| EDUCATION             |  |
| MILITARY SERVICE      |  |
| PREVIOUS ILLNESS      |  |
| TREATMENT             |  |
| HISTORY               |  |
| FAMILY HISTORY        |  |
| SOCIAL HISTORY        |  |
| PHYSICAL EXAMINATION  |  |
| LABORATORY TESTS      |  |
| PATHOLOGICAL FINDINGS |  |
| DIAGNOSIS             |  |
| TREATMENT             |  |
| PROGNOSIS             |  |
| FOLLOW-UP             |  |
| SIGNATURE             |  |
| DATE                  |  |



1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |  |  |  |   |  |   |  |  |
|--|--|--|--|---|--|---|--|--|
| 05067  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |  |   |  | 05059   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>ETHEL BEAUCHAMP HOLLOWAY</b>   |  |  | 2a. DATE OF DEATH<br>4 <sup>Month</sup> 29 Day 69 Year |   |  | 2b. HOUR<br>9:20 <sup>P</sup>   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>2-19-85   |  | 6. AGE (In years last birthday)<br>84 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREAT BALT MED CENTR.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Harford</b>  |  | 13c. CITY OR TOWN<br><b>Perryman,</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Willard Henry Hinchman (D)</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ella Stockham (D)</b>                                       |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown   |  | 16b. SOCIAL SECURITY NO.<br><b>220-34-6300</b>   |  | 17. INFORMANT Address<br><b>Gertrude Spang, Aberdeen, Maryland</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CA WITH HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>LONG STANDING</b> |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1969   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-25, 1969, to 4-29, 1969, that (x) (we) last saw the deceased alive on 4-29, 1969, and that in (x) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Neeraja Thakur</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>           |  | 22c. DATE SIGNED<br>4/29/69   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. NEERAJA THAKUR</b>  |  |  |  | 22e. ADDRESS<br><b>Baltimore, Maryland</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br>2 May 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spesutia Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Perryman, (Harford Co.) Md.</b>             |  |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Macomber Jr.</b>   |  |  |  | 24a. ADDRESS<br><b>Aberdeen, Md. 21001</b>  |  | 24b. REC'D BY REGISTRAR<br><b>MAY 2 1969</b>  |  |  |
|  |  |  |  | 25a. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |

000000

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

|                        |  |                 |  |
|------------------------|--|-----------------|--|
| 1. NAME OF THE OFFICER |  | 2. GRADE        |  |
| 3. BRANCH              |  | 4. POST         |  |
| 5. DATE                |  | 6. TIME         |  |
| 7. PLACE               |  | 8. SUBJECT      |  |
| 9. REASON FOR REQUEST  |  | 10. ACTION      |  |
| 11. APPROVED           |  | 12. DISAPPROVED |  |
| 13. COMMENTS           |  | 14. SIGNATURE   |  |
| 15. DATE               |  | 16. TIME        |  |
| 17. PLACE              |  | 18. SUBJECT     |  |
| 19. REASON FOR REQUEST |  | 20. ACTION      |  |
| 21. APPROVED           |  | 22. DISAPPROVED |  |
| 23. COMMENTS           |  | 24. SIGNATURE   |  |
| 25. DATE               |  | 26. TIME        |  |
| 27. PLACE              |  | 28. SUBJECT     |  |
| 29. REASON FOR REQUEST |  | 30. ACTION      |  |
| 31. APPROVED           |  | 32. DISAPPROVED |  |
| 33. COMMENTS           |  | 34. SIGNATURE   |  |
| 35. DATE               |  | 36. TIME        |  |
| 37. PLACE              |  | 38. SUBJECT     |  |
| 39. REASON FOR REQUEST |  | 40. ACTION      |  |
| 41. APPROVED           |  | 42. DISAPPROVED |  |
| 43. COMMENTS           |  | 44. SIGNATURE   |  |
| 45. DATE               |  | 46. TIME        |  |
| 47. PLACE              |  | 48. SUBJECT     |  |
| 49. REASON FOR REQUEST |  | 50. ACTION      |  |
| 51. APPROVED           |  | 52. DISAPPROVED |  |
| 53. COMMENTS           |  | 54. SIGNATURE   |  |
| 55. DATE               |  | 56. TIME        |  |
| 57. PLACE              |  | 58. SUBJECT     |  |
| 59. REASON FOR REQUEST |  | 60. ACTION      |  |
| 61. APPROVED           |  | 62. DISAPPROVED |  |
| 63. COMMENTS           |  | 64. SIGNATURE   |  |
| 65. DATE               |  | 66. TIME        |  |
| 67. PLACE              |  | 68. SUBJECT     |  |
| 69. REASON FOR REQUEST |  | 70. ACTION      |  |
| 71. APPROVED           |  | 72. DISAPPROVED |  |
| 73. COMMENTS           |  | 74. SIGNATURE   |  |
| 75. DATE               |  | 76. TIME        |  |
| 77. PLACE              |  | 78. SUBJECT     |  |
| 79. REASON FOR REQUEST |  | 80. ACTION      |  |
| 81. APPROVED           |  | 82. DISAPPROVED |  |
| 83. COMMENTS           |  | 84. SIGNATURE   |  |
| 85. DATE               |  | 86. TIME        |  |
| 87. PLACE              |  | 88. SUBJECT     |  |
| 89. REASON FOR REQUEST |  | 90. ACTION      |  |
| 91. APPROVED           |  | 92. DISAPPROVED |  |
| 93. COMMENTS           |  | 94. SIGNATURE   |  |
| 95. DATE               |  | 96. TIME        |  |
| 97. PLACE              |  | 98. SUBJECT     |  |
| 99. REASON FOR REQUEST |  | 100. ACTION     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05060  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>GUSTAF</b> First <b>W.</b> Middle <b>HOLMGREN</b> Last   |  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1969</b>     |   |  | 2b. HOUR<br><b>5<sup>10</sup> PM</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>Dec. 30, 1916</b>  |  | 6. AGE (In years last birthday)<br><b>52</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Cen.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8207 Lockraven Blvd.</b>                  |  |
| 14. FATHER'S NAME<br>First <b>Rudolph</b> Middle <b>Holmgren</b> Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Dorothy</b> Middle <b>Warner</b> Last |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>Yes</b> (If yes, in what branch of service)<br><b>WW 2</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>043-07-1342</b>  |  | 17. INFORMANT<br><b>Mrs. Lois Holmgren</b>  |  | Address<br><b>Towson, Md. 21204</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DIABETIC GLOMERULOSCLEROSIS</b><br><b>2509</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DIABETES MELLITUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YEARS</b><br><b>2 1/2 YEARS</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>MARCH</b> , 19 <b>67</b> , to <b>April 30</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 7</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard H. Gendason MD.</b> DEGREE  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>April 30, 1969</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>HOWARD H. GENDASON MD.</b>   |  |   |  | 22e. ADDRESS<br><b>REISTERS TOWN, MD.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 5, 69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons</b>   |  |   |  | ADDRESS<br><b>Reisterstown, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 5 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05069

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05061

|  |  |   |   |   |   |   |  |   |  |                                |  |
|--|--|---|---|---|---|---|--|---|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>William  | Middle:<br>Hoyt   | Last<br>(Hoyte)   | 2a. DATE OF DEATH<br>Month Day Year<br>April 13, 1969   |   | 12b. HOUR<br>a. M<br>10:00   |   |  |                                |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>10/12/1879  |   | 6. AGE (In years<br>last birthday)<br>89 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>laborer |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Packing Ind. |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  |   | 13b. COUNTY<br>BALTO.   |   | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>Baltimore City Hospitals   |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>JOHN HOYT  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>ELIZABETH BRODER   |   |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-54-3165J1                                       |   | 17. INFORMANT<br>Address<br>Records : SPRING GROVE STATE HOSPITAL   |   |   |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br><u>485X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____       |  |   |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |   |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 14</u> , 19 <u>13</u> , to <u>April 13</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>April 13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |  |   |  |                                |  |
| 22b. SIGNATURE<br><u>Rafael H. Marin</u>   |  |   |   |   | DEGREE<br>ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-14-69  |   |  |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Rafael H. Marin, M.D.   |  |   |   |   | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-16-69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SCHWARTZ CEM.   |   | 23d. LOCATION (City or Town) (County) (State)<br>BALTO., Md.  |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>2334<br>John A. Miller Funeral Home  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE APR 15 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |   |  |                                |  |

02083

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05070

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05062

|   |                         |   |   |   |   |   |   |
|---|-------------------------|---|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>Wilbert</b>   | Middle<br><b>A.</b>                               | Lost<br><b>Huffman</b>  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <b>APR</b> Day <b>17</b> Year <b>1969</b>                |   | 2b. HOUR<br><b>11 A</b> M                                     |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>11/10/11</b>   | 6. AGE (In years last birthday)<br><b>57</b> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>17</b> Year <b>1969</b>   | 2d. HOUR<br><b>11 45</b> M                                    |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1 Midway</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired-Bethlehem Steel Co.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>1 Midway</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 14. FATHER'S NAME<br>First <b>Walter</b> Middle <b>A.</b> Lost <b>Huffman</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>First <b>Lula</b> Middle <b>Belle</b> Lost <b>Phillips</b>          |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>218-01-2526</b>  |                         | 17. INFORMANT (Wife)<br>ADDRESS<br><b>Mrs. Mable Huffman, 1 Midway, Dundalk, Md.</b>            |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                                 |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |   |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |   |   |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                         | EXAMINER'S NAME (Type)<br><b>Melvin B. Davis</b>  |   | M.D.<br><b>M. D.</b>  |   | 22b. DATE SIGNED <b>4/18/69</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Mornington Road Dundalk, Md. 21222</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/21/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorsey, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 21 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

05074

11/12/2000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05071

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05063

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Wm. LESTER</b>   |  |  | First Middle Last   |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>April 1, 1969</b>  |  |  | 2b. HOUR <b>5:50p</b>  |  |  |
| 3. SEX <b>Male</b>  |  |  | 4. RACE <b>White</b>  |  |  | 5. DATE OF BIRTH <b>10/22/08</b>   |  |  | 6. AGE (In years last birthday) <b>60</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. COUNTY OF DEATH <b>Balto.</b>   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>In Auto outside 1200 Burkwood Rd.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  |  | 13b. COUNTY <b>Balto.</b>   |  |  | 13c. CITY OR TOWN <b>Essex</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME <b>LAWRENCE HUGHES</b>  |  |  | 15. MOTHER'S MAIDEN NAME <b>ANNA TUEFEL</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>220-14-1519</b>  |  |  |
| 17. INFORMANT <b>FAYE HUGHES</b>  |  |  | ADDRESS <b>ABOVE</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4124 Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Edw F Wilson</b>  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <b>4/2/69</b>   |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>  |  |  | ADDRESS (Street, city, town, or county)   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  |  | 23b. DATE <b>4/4/69</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NAT.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>                              |  |  |
| 24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>  |  |  |   |  |  | ADDRESS <b>300 MACE</b>  |  |  | 25a. REC'D BY REGISTRAR <b>APR 7 1969</b>  |  |  |
|   |  |  |   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |  |  |

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
MEDICAL EXAMINER'S REPORT OF DEATH

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
MEDICAL EXAMINER'S REPORT OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
|---|--|--|--|--|--------|--|--|----------------------|--|--|------------------|---|--|---|-----------|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 05072   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 05064   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  | Middle |  | Last   |                      | 2a. DATE OF DEATH  |  | 2b. HOUR         |   |  |   |           |                  |  |
| THOMAS  |  |  | H.   |  | HUNT   |  |  |                      | 4  |  | Month 14 Day 189 |   |  |   |           |                  |  |
| 3. SEX  |  |  | 4. RACE  |  |        | 5. DATE OF BIRTH   |  |                      | 6. AGE (In years lost birthday)  |  |                  | IF UNDER 1 YEAR MONTHS DAYS                   |  |   |           |                  |  |
| M   |  |  | W  |  |        | Aug 15 1895  |  |                      | 73 YRS.  |  |                  |   |  |   |           |                  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                      | 9. COUNTY OF DEATH   |  |                  | Md.   |  |   |           |                  |  |
| Md  |  |  | U.S.A  |  |        |  |  |                      | BALTIMORE  |  |                  |   |  |   |           |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                  |   |  |   |           |                  |  |
| CATONSVILLE   |  |  | 129 OAKDALE  |  |        | CLERK  |  |                      | GOVERNMENT   |  |                  |   |  |   |           |                  |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE   |  |  | 13b. COUNTY  |  |        | 13c. CITY OR TOWN  |  |                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  | 13e. STREET AND NUMBER                        |  |   |           |                  |  |
| Md  |  |  | BALTIMORE  |  |        | CATONSVILLE  |  |                      |  |  |                  | 129 OAKDALE                                   |  |   |           |                  |  |
| 14. FATHER'S NAME   |  |  | First  |  | Middle |  | Last   |                      | 15. MOTHER'S MAIDEN NAME   |  |                  | First   |  | Middle  |           | Last             |  |
| THOMAS  |  |  | H.   |  | HUNT   |  |  |                      | EMMA S. HUNT   |  |                  | 129 OAKDALE                                   |  | BALTIMORE   |           | HAINES           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |        | 17. INFORMANT  |  |                      | Address  |  |                  |   |  |   |           |                  |  |
| YES   |  |  | WW I   |  |        | 212-07-2318  |  |                      | EMMA S. HUNT   |  |                  | 129 OAKDALE                                   |  |   | BALTIMORE |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |        |  |  |                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |   |  |   |           |                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |        |  |  |                      |  | 4 hours                                      |                  |   |  |   |           |                  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |        |  |  |                      |  | 4122   |                  |   |  |   |           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |        |  |  |                      |  | (b) Congestive Heart Failure                 |                  |   |  |   |           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |        |  |  |                      |  | (c) Myocardial Infarction                    |                  |   |  |   |           |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                  |   |  |   |           |                  |  |
|   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY  |  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                      |  |  |                  |   |  |   |           |                  |  |
|   |  |  | HOUR A.M. Month Day Year P.M. 19   |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |        | 21f. LOCATION  |  | Street or R.F.D. No. |  | City or Town                                 |                  | County  |  | State   |           |                  |  |
|   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1960, to _____, 1964, that (I) (we) last saw the deceased alive on _____, 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Regular patient of DR. H. Knapp who is on record |  |  |  |  |        |  |  |                      |  | 22b. SIGNATURE                               |                  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |           | 22c. DATE SIGNED |  |
|   |  |  |  |  |        |  |  |                      |  |  |                  |   |  |   |           | 4-16-69          |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS   |  |        | 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE            |  | 23c. NAME OF CEMETERY OR CREMATORY           |                  | 23d. LOCATION (City or Town) (County) (State) |  |   |           |                  |  |
| Burial  |  |  | 4/18/1969  |  |        | ST. John   |  |                      |  | Ellicott City                                |                  | BALT. Md                                      |  |   |           |                  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. REG'D BY REGISTRAR  |  |        | 25b. REGISTRAR'S SIGNATURE   |  |                      |  |  |                  |   |  |   |           |                  |  |
| E.S. McEuback   |  |  | 301 Frederick Rd. 21228  |  |        | APR 21 1969  |  |                      |  |  |                  |   |  |   |           |                  |  |

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| 05073   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05065   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>HUNTER</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>69</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>1:45</b> P <b>M</b>   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>FEMALE</b>  |  |  |  |  |  |  |  |  |  | 4. RACE <b>NEGRO</b>   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH <b>10/18/24</b>  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>G.B.M.C.</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Householder</b>  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>                            |  |  |  |  |  |  |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>Charles</b> Middle <b>Hunter</b> Last <b>Johnson</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Virginia</b> Middle <b>Johnson</b> Last <b>Johnson</b>   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  |  |  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>215-24-1029</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address <b>Mr. Charles Hunter 2552 Hollins Ferry Rd.</b>   |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ANEURYSM OF CIRCLE OF WILLIS</b>                                       |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>  |  |  |  |  |  |  |  |  |  | WITH SUBARACHNOID HEMMORHAGE  |  |  |  |  |  |  |  |  |  |
| 4309  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                      |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |  |  |  |  |  |  |  |  | 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |  |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>4-3-</b> , 19 <b>69</b> , to <b>4-4-</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-4-</b> , 19 <b>69</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <del>not</del> view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Charles C. Brown, M.D.</b>  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <b>4/4/69</b>  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>CHARLES C. BROWN</b>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <b>6701 N CHARLES ST., BALT., MD</b>  |  |  |  |  |  |  |  |  |  | 23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  |  |  |  |  |  |  |
| 23b. DATE <b>Apr. 8, 1969</b>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lukum Cem.</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph L. Ruz</b>   |  |  |  |  |  |  |  |  |  | ADDRESS <b>2222 W. North Ave</b>   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <b>APR 11 1969</b>  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>John H. Young</b>   |  |  |  |  |  |  |  |  |  | DATE <b>APR 11 1969</b>  |  |  |  |  |  |  |  |  |  | 25c. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Charles Edward Husen, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>22</b> Year <b>1969</b>                    |   |  | 2b. HOUR<br><b>1:20 M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br><b>6-15-43</b>  |  | 6. AGE (In years last birthday)<br><b>25</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>AIRCRAFT ARMAMENT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AIRCRAFT</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4421 St. George Ave. #12</b>              |  |
| 14. FATHER'S NAME First <b>Charles</b> Middle <b>E.</b> Last <b>Husen, Sr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME First <b>Charlotte</b> Middle <b>Ringgold</b> Last <b>Swartz</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>YES</b>  |  | (If yes give war or dates of service)<br><b>VIETNAM</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-40-1029</b>  |  | 17. INFORMANT<br><b>Charlotte Ringgold</b> Address <b>411 SWARTZ AVE.</b>                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral and pontine hemorrhage</b><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                 |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 21</b> , 19 <b>69</b> , to <b>April 22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>April 22</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>April 22, 1969</b>   |  | 22d. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-25-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NAT.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. Md.</b>                              |  | 23e. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett Funeral Home, 1701</b>  |  | 24a. ADDRESS<br><b>Laurens St. Balto. Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 23 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

05032

STATE OF DEATH

NAME: Charles Edward  
AGE: 35  
SEX: Male  
DATE OF BIRTH: April 22, 1902  
PLACE OF BIRTH: St. Louis, Mo.

DECEASED: April 23, 1937  
PLACE OF DEATH: St. Louis, Mo.

CAUSE OF DEATH: Heart disease

REPORTED BY: Dr. J. H. Jones

SIGNATURE: J. H. Jones

TESTIFYING: J. H. Jones

WITNESSES: J. H. Jones

INTERVIEWED: J. H. Jones

EXAMINED: J. H. Jones

TESTIFIED: J. H. Jones

EXAMINED: J. H. Jones

TESTIFIED: J. H. Jones

EXAMINED: J. H. Jones

TESTIFIED: J. H. Jones

EXAMINED: J. H. Jones

TESTIFIED: J. H. Jones

EXAMINED: J. H. Jones

TESTIFIED: J. H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
| 05075   |  |   |  |   |  |   |  |   |  |
| 05067   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Viola<br/>OLIE</b>  |  | Middle<br><b>M.</b>   |  | Last<br><b>IRVIN</b>  |  | 2a. DATE OF DEATH<br><b>4</b> Month <b>16</b> Day <b>69</b> Year                                |  | 2b. HOUR<br><b>4:30</b> M                                       |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>3-17-95</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Penn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto</b>  |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randalltown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>State Co. Genl.</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>At Home</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>136. COUNTY</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3402 Woodbine Ave.</b>             |  |
| 14. FATHER'S NAME First<br><b>Howard</b>  |  | Middle<br><b>Shingler</b>   |  | Last<br><b>Shingler</b>   |  | 15. MOTHER'S MAIDEN NAME First<br><b>Vanallman</b>  |  | Middle<br><b>Vanallman</b>                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>-</b>                             |  | 17. INFORMANT<br><b>Chart</b>   |  | Address<br><b>Jacqueline Sullivan</b>   |  | <b>3402 W</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b><br>4109<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Infarction of Myocardium -</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>4-9-69</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma Breast</b>                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. Perez-Mera</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                       |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>R. Perez-Mera</b>   |  | 22e. ADDRESS  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-18-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moorestville Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Neffs Mills PA</b>                          |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Armacost Funeral Chapel - 4600 Liberty Road</b>  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>APR 18 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |   |  |





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05076

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05068

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>WILLIAM HENRY JACKSON</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 18, 1969</b> |   | 2b. HOUR<br><b>5:30 AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>NEGRO</b>                       | 5. DATE OF BIRTH<br><b>8/27/18</b>  |  | 6. AGE (In years last birthday)<br><b>50</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMIN. HOSPITAL</b>   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>KILN LOADER</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               | 13e. STREET AND NUMBER<br><b>2749 ROUND ROAD</b>                        |
| 14. FATHER'S NAME First Middle Last<br><b>ALFRED - - JACKSON</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SARAH - - RANSOME</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>YES WWII</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212 14 0814</b>  |  | 17. INFORMANT Address<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br><b>582X</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>VENTRICULAR FAILURE, LEFT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO CHRONIC NEPHRITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                    |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HOURS<br>YEARS<br>YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                               |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APR 8, 1969</b> , to <b>APR 18, 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APR 18, 1969</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Alfonso A. Lopez</b>   |   |   |  | 22c. DATE SIGNED<br><b>4 19 69</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ALFONSO A. LOPEZ, M.D.</b>   |   |   |  | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>4/22/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEMETERY</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>  |   |   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT FUN. DIR. BALTO., MD.</b>   |   |   |  | 25a. REGD BY REGISTRAR<br><b>APR 21 1969</b>  |   |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |   |  |  |  |
|---|--|--|--|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |  |
| Edith Mae Jasper  |  |  |  |  |  | April Month 29, 1969 Year   |   | 1220 P.M.  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |  |
| Female  |  | Colored m  |  | Nov. 30, 1898  |  | 70 YRS.   |   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |  |  |  |
| Balto. Md.  |  | U.S.A.   |  |  |  | Balto. Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |  |
| Halethorpe  |  |  | 4511 Spring Ave.   |  |  | Housewife   |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.   |  |  | Balto.   |  | Halethorpe   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 4511 Spring Ave.                             |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |   |  |  |  |
| Lorenzo Barron  |  |  | Catherine Madden   |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |   |  |  |  |
| No  |  |  |  |  | Katherine Littles 1730 Moreland Ave.                                   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4122 HYPERTENSIVE + ATHEROSCLEROTIC CUX<br>DUE TO, OR AS A CONSEQUENCE OF DISEASE - CHRONIC<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE FAILURE<br>(c) |  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CEREBRAL ATHEROSCLEROSIS SENILE DEMENTIA.  |  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |
|   |  |  |  |  |  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |  |  |
|   |  | 19   |  |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |   | County State   |  |  |
|   |  |  |  |  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |   |   |  |  |  |
| John F. Schaefer M.D.   |  | 5-1-69   |  |  |  |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |   |   |  |  |  |
| JOHN F. SCHAEFER  |  | 401 RANDOM ROAD - 21229  |  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |   |  |  |  |
| Burial  |  | May 2, 1969  |  | Balto. National Cem.   |  | Balto. Md.  |   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |  |  |
| William S. Schaefer   |  |  |  | MAY 5 1969   |  | W. Schaefer   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |  |  |   |  |  |
|---|--|--|--|--|---|---|--|--|---|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |  |   |  |  |
| 1. DECEASED-NAME (Type or print) <i>Katherine Marie Jasper</i>  |  |  |  |  |   | 2a. DATE OF DEATH <i>April 24 1969</i>  |  |  | 2b. HOUR <i>5:30 A.M.</i>                               |  |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>W</i>   |  | 5. DATE OF BIRTH <i>Oct. 28, 1900</i>  |   | 6. AGE (In years last birthday) <i>68</i> YRS.  |  | IF UNDER 1 YEAR MONTHS   |   | IF UNDER 24 HRS. HOURS MIN.                                  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <i>Baltimore</i> Md.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <i>Carney</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9620 Oak Summit Rd. 34</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>                        |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  |  | 13b. COUNTY <i>Baltimore</i>   |  | 13c. CITY OR TOWN <i>Carney</i>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <i>9620 Oak Summit Rd. 21234</i> |  |  |
| 14. FATHER'S NAME First <i>Herman</i> Middle <i>Frederick</i> Last <i>Schwartz</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Caroline</i> Middle <i>Margaret S.</i> Last <i>Dietz</i>   |   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. <i>212-52-6580</i>  |  | 17. INFORMANT Address <i>Edwin F. Jasper 9620 Oak Summit Road 21234</i> |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer Uterus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arterio sclerotic CVD Perkinson's</i>  |  |  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>April 1969</i> , that (I) (we) lost the deceased alive on <i>April 22 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE <i>William A. Tyson M.D.</i> DEGREE  |  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <i>4-24-69</i>                                      |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>  |  |  |  |  |   | 22e. ADDRESS <i>Kingsville, Md.</i>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <i>Apr 28-1969</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Michael's Lutheran</i>   |   | 23d. LOCATION (City or Town) (County) (State) <i>Perry Hall Balto. Md.</i>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <i>Lassahn Funeral Home 7401 Belair Road 21236</i>   |  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE <i>APR 28 1969</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>                   |   |  |  |

25070



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05079

CERTIFICATE OF DEATH

05071

|   |  |  |  |   |  |   |   |   |   |  |  |
|---|--|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>St. Mary Agnes Jindra</i>  |  | First <i>(St. Mary)</i> Middle <i>Agnes</i> Last <i>Jindra</i>               |  | 2a. DATE OF DEATH<br>Month <i>4</i> Day <i>3</i> Year <i>69</i>   |  |   | 2b. HOUR<br><i>4:15</i> M                         |   |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>1-18-1899</i>  |  |   | 6. AGE (In years last birthday)<br><i>70</i> YRS. |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.        |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Arm</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Glen Arm Road</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Teacher</i>                       |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><i>md.</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |   |  | 13c. CITY OR TOWN<br><i>Glen Arm, Md.</i>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First <i>Mathias</i> Middle <i>Jindra</i> Last <i>Petronila</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Boreas</i> Middle <i>Bores</i> Last <i>Bores</i>   |  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown<br><i>No</i>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>830-54-5098-7</i>  |  |   |   | 17. INFORMANT<br><i>St. M. Kathleen</i> Address <i>same</i>                     |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Gastrointestinal Bleeding 20 To 25</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Multiple myeloma.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>203X</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December, 1966</i> , to <i>April 3, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 3rd 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.                                  |  |  |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Henry L McCorkle</i>   |  |  |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>4-5-69</i>   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Henry L McCorkle MD</i>  |  |  |  | 22e. ADDRESS<br><i>Phoenix, Md 21131</i>  |  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>4-7-69</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SISTERS CEMETERY</i>   |  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>GLEN ARM BALT. MARYLAND</i> |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>RAYMOND J. CURRAN</i>  |  |  |  | ADDRESS<br><i>817 SCARLETT DR<br/>TOWSON, MD. 21204</i>   |  | 25a. REC'D BY REGISTRAR<br><i>APR 14 1969</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                              |   |  |  |

2000

05080

## CERTIFICATE OF DEATH

05072

|  |  |   |   |   |   |   |   |   |  |
|--|--|---|---|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ETHEL BEASTON JOHNSON</b>   |  |   | 2a. DATE OF DEATH<br><b>April</b> Month <b>6</b> Day <b>1969</b> Year |   |   | 2b. HOUR<br><b>M</b>  |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br><b>9-29-1887</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>81</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Dulaney-Towson Nursing Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Dumbarton Road</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Theodore Lewis</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sara</b>             |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>214-46-8556</b>  |   | 17. INFORMANT Address<br><b>Shirley J. Hannon, 107 Aylesbury St. 21093</b>  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio sclerotic Cardio Vascular Disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |   |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 4<sup>th</sup>, 1968</b> , to <b>April 6<sup>th</sup>, 1969</b> , that (I) <del>(we)</del> last<br>saw the deceased alive on <b>April 5<sup>th</sup>, 1969</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |  |   |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>M. K. Quinn MD</b> DEGREE   |  |   |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |   | 22c. DATE SIGNED<br><b>4/8/69</b>   |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>M. K. QUINN MD</b>   |  |   |   | 22e. ADDRESS<br><b>1927 York Rd TIMONHART MD</b>  |   |   |   |   |  |
| 23a. BURIAL, CREMATION,<br>or other (Specify)  |  | 23b. DATE<br><b>4-9-1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Maryland</b>                    |   |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wm. Cook-Brooks Towson, 1050 York Road<br/>Towson, Maryland 21204</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>APR 9 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02080

02080



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-78B

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|
| 05081  |  |  |  |   | 05073  |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                                     |  |  |
| First Middle Last<br>Geneva Pearl Johnson  |  |  |  |   | Month Day Year<br>4 18 1969  |   |  | 10:30 AM                                     |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>1898  |  | 6. AGE (In years last birthday)<br>71 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore 21228   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Caton Ridge Nursing Home |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>—   |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>725 George St. 21217 |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN ELLIOTT  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth Paige  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.<br>215-05-9285-A  |   | 17. INFORMANT Address<br>Eaton Ridg Nursing Home-329 Harlem Lane   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brouchpneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
|  |  |  |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Generalized Arteriosclerosis - Chronic Brain Syndrome</u>  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Cesar Valle Cervero</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-21-69  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CESAR VALLE CAVERO   |  |  |  |   | 22e. ADDRESS<br>86 29 Liberty Rd   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4-21-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                    |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>1701-31 LaYett St., Balto., Md. 21217  |  |  |  |   | 25a. DATED BY REGISTRAR<br>APR 21 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John A. Judge</u>                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |  |  |                                   |                                   |  |
|---|--|---|---|---|---|--|--|-----------------------------------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |  |  |                                   |                                   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |                                   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First   |   | Middle  |  | Last   |                                   | 2a. DATE OF DEATH                 |  |
| HELEN   |  |   | D.  |   | JOHNSON   |  | APRIL  |                                   | Month 29, Day 1969 Year           |  |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |   |  | 6. AGE (In years lost birthday)                                      |                                   | 2b. HOUR                          |  |
| FEMALE  |  | WHITE   |   | NOVEMBER 25, 1895   |   |  | 75 YRS.  |                                   | 11:00P                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |   | 7b. CITIZEN OF WHAT COUNTRY?  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                |                                   |  |
| ILLINOIS  |  |   | U.S.A.  |   |   |  |  | BALTIMORE, Md.                    |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| TOWSON  |  |   | JOSEPH HOSPITAL   |   |   | HOMEMAKER  |  |                                   |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |   | 13b. CITY OR TOWN   |   |   | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET AND NUMBER            |                                   |  |
| MARYLAND  |  |   | BALTIMORE   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 7500 HARFORD RD. #21234           |                                   |  |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME  |   |   |  |  |                                   |                                   |  |
| First Middle Lost   |  |   | First Middle Lost   |   |   |  |  |                                   |                                   |  |
| CHARLES F. DEWEND   |  |   | ANNA KUSCHMAN   |   |   |  |  |                                   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   |  |   | 16b. SOCIAL SECURITY NO.  |   |   | 17. INFORMANT Address  |  |                                   |                                   |  |
| No  |  |   | 220-1402488   |   |   | Hospital records   |  |                                   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |   |  |  |                                   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |   |   |   |   |  |  |                                   |                                   |  |
| IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage  |  |   |   |   |   |  |  |                                   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |   |  |  |                                   |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |   |   |   |  |  |                                   |                                   |  |
| Berry aneurysm of the right posterior communicating artery  |  |   |   |   |   |  |  |                                   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |   |  |  |                                   |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                                   |  |
|   |  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                                   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |                                   |                                   |  |
|   |  | HOUR A.M. Month Day Year P.M. 19  |   |   |   |  |  |                                   |                                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |                                   |                                   |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |   |   |   |  |  |                                   |                                   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 29, 1969, to April 29, 1969, that (X) (we) lost saw the deceased alive on April 29, 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |                                   |                                   |  |
| 22b. SIGNATURE  |  |   |   |   |   |  |  | 22c. DATE SIGNED                  |                                   |  |
| Lawrence Misanik, M.D.  |  |   |   |   |   |  |  | 4-30-69                           |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |   |   |   |  |  | 22e. ADDRESS                      |                                   |  |
|   |  |   |   |   |   |  |  | 7620 York Road, Towson, Md. 21204 |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |                                   |  |
| Burial  |  | 5/2/69  |   | Parkwood cemetery   |   | Balto Co. Md.  |  |                                   |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |   |   |   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE        |                                   |  |
| C.F. EVANS & SON 8802 Harford road  |  |   |   |   |   | MAY 2 1969   |  | Charles Judge                     |                                   |  |

05029

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

RECEIVED  
JAN 11 1964  
COMMUNICATIONS SECTION

TO : DIRECTOR, FBI (100-354618)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [REDACTED]  
RE: [REDACTED]  
100-100000-100000  
JAN 11 1964  
NEW YORK

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 05083   |  |  |  |   |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
| 05075   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print)<br>First Middle Last<br><b>Louis C. Kafer</b>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month Day Year<br><b>April 9, 1969</b>        |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br><b>DEC. 27, 1916</b>  |  | 6. AGE (In years last birthday)<br><b>52</b> YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 9, 1969</b>                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SPARROWS PT. 21219</b>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Beth Steel Sp. Pt. Hosp.</b>   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>YARDMASTER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  |  |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>AUGUST KAFER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MAGADELENA MARKEL</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-09-4127</b>  |  | 17. INFORMANT ADDRESS<br><b>ANNA K. KAFER AS IN # 13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Hypertensive Cardio-vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>M.B. Davis</b>   |  | EXAMINER'S NAME (Type)<br><b>M.B. DAVIS MD-6800 MORRISON</b>                 |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |  |
|   |  |  |  | ADDRESS Street, city, town, or county<br><b>Dundalk Md - 21222</b>  |  | 22b. DATE SIGNED<br><b>4-9-69</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11, APRIL 69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GRDNS. FAITH</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. CO., MD</b>                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. Brooks Bradley</b>  |  |  |  | ADDRESS<br><b>DUNDALK, MD. 21222</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 11 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. Brooks Bradley</b>                               |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
|---|---------|------------------|--|------------------------------------|--------|--|-------------|---|---|--|-----------------------------------|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First  |                                    | Middle |  | Last        |   | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                          |                   |  |
| JOHN M. KLAFKA  |         |                  |  |                                    |        |  | SR KAFKA SR |   | Month 7 Day 7 Year 1969   |  | 5 PM                              |                   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years lost birthday)  | IF UNDER 1 YEAR                    |        | IF UNDER 24 HRS.   |             | 2c. DATE PRONOUNCED DEAD  |   | 2d. HOUR                                     |                                   |                   |  |
| M   | W       | 4/20/07          | 61 YRS.  | MONTHS DAYS                        |        | HOURS MIN.   |             | Month 4 Day 7 Year 1969   |   | 6 PM   |                                   |                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |             | 9. COUNTY OF DEATH  |   | Md.  |                                   |                   |  |
| OHIO  |         |                  | USA  |                                    |        |  |             | BALTO   |   |  |                                   |                   |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |        |  |             |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                   |  |
| ESSEX   |         |                  | 519 WELLBROOK AVE  |                                    |        |  |             |   | ENGINEER  |  |                                   |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                                    |        | 13c. CITY OR TOWN  |             | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |                                   |                   |  |
| MD.   |         |                  | BALTO.   |                                    |        | ESSEX  |             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 519 WELLBROOK                                |                                   |                   |  |
| 14. FATHER'S NAME   |         |                  | First  |                                    | Middle |  | Last        |   | 15. MOTHER'S MAIDEN NAME  |  |                                   | First Middle Last |  |
| JOHN M. KLAFKA  |         |                  |  |                                    |        |  | KAFKA       |   | UNK   |  |                                   |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.   |                                    |        | 17. INFORMANT  |             |   | ADDRESS   |  |                                   |                   |  |
| UNK   |         |                  | 029-05-8779  |                                    |        | EDITHE KLAFKA  |             |   | ABOVE   |  |                                   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |  |                                    |        |  |             |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                   |                   |  |
| PART 1. DEATH WAS CAUSED BY:  |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| IMMEDIATE CAUSE (a) 4109 Coronary Occlusion   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| (b) A-S-C-V-DISEASE   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| (c)   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                    |        |  |             |   | 20. AUTOPSY?  |  |                                   |                   |  |
|   |         |                  | None   |                                    |        |  |             |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |                                   |                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                                    |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |             |   |   |  |                                   |                   |  |
|   |         |                  | 19 P.M.  |                                    |        |  |             |   |   |  |                                   |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                    |        | 21f. LOCATION Street or R.F.D. No.   |             |   | City or Town County State   |  |                                   |                   |  |
|   |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                                    |        |  |             |   |   |  |                                   |                   |  |
| ACTUAL SIGNATURE  |         |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |                                    |        |  |             |   | 22b. DATE SIGNED  |  |                                   |                   |  |
| M.B. Davis  |         |                  |  |                                    |        |  |             |   | 4/10/69   |  |                                   |                   |  |
| EXAMINER'S NAME (Type)  |         |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |                                    |        |  |             |   |   |  |                                   |                   |  |
| MELVIN B. DAVIS MD  |         |                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |                                    |        |  |             |   |   |  |                                   |                   |  |
|   |         |                  | ADDRESS (Street, city, town, or county)                                      |                                    |        |  |             |   | 6800 HORNINGTON RD 21222  |  |                                   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE        |  | 23c. NAME OF CEMETERY OR CREMATORY |        |  |             | 23d. LOCATION (City or Town) (County) (State)                       |   |  |                                   |                   |  |
| BURIAL  |         | 4/10/69          |  | MORELANDS                          |        |  |             | BALTO. MD.  |   |  |                                   |                   |  |
| 24. FUNERAL DIRECTOR  |         |                  |  | ADDRESS                            |        |  |             | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                   |                                   |                   |  |
| J.G. CONNELLY SONS  |         |                  |  | 300 MACE                           |        |  |             | APR 14 1969   |   | Charles Judge                                |                                   |                   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 05085  |  |  |  |  | 05077   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH Baltimore<br>a. COUNTY CATONSVILLE 28 MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CATON RIDGE NURSING HOME |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY BALTIMORE<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore 21230<br>d. STREET ADDRESS 2030 Whistler Avenue<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last CLARA KARL<br>4. DATE OF DEATH Month Day Year APRIL 20 1969  |  |  |  |  | 8. DATE OF BIRTH 11-1-1899 9. AGE (In years last birthday) 69 10. IF UNDER 1 YEAR Months Days Hours Min.  |  |  |  |  |
| 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 213-18-0473-A  |  |  |  |  | 13. FATHER'S NAME John Griffin 14. MOTHER'S MAIDEN NAME Clara Sinclair  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 213-18-0473-A 17. INFORMANT Address 21230 Caton Ridge Nursing Home - 329 Harbortowne   |  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis (CVA)<br>4339 DUE TO (b) Generalized Arteriosclerosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)                            |  |  |  |  | 21. I certify that (I) (this hospital) attended the deceased from 11-21-1967 to 4-20-1969, that (I) (we) last saw the deceased alive on 4-20-1969, and that death occurred at M, from the causes and on the date stated above.  |  |  |  |  |
| 22a. SIGNATURE Cesar Valle Caveru M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-21-69  |  |  |  |  | 22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERU 22d. ADDRESS 8629 Liberty   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/24/69 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Md.   |  |  |  |  | 24. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., Balto., Md. 21229 25a. REC'D BY REGISTRAR APR 24 1969 25b. REGISTRAR'S SIGNATURE J Charles Judge  |  |  |  |  |

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THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C. 20315

TO: THE ADJUTANT GENERAL  
FROM: THE ADJUTANT GENERAL  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| 05086  |                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |  |   |                                    | 05078   |   |
|--|------------------------------|---|--|---|------------------------------------|---|---|
| CERTIFICATE OF DEATH   |                              |   |  |   |                                    |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |                              | First   | Middle   | Lost  | 2a. DATE OF DEATH                  |   | 2b. HOUR  |
| Anna   |                              | Bertha  | Kasten   |   | April Month 14 Day 1969 Year       |   | 5 <sup>03</sup> P M   |
| 3. SEX   | 4. RACE                      |   | 5. DATE OF BIRTH   |   | 6. AGE (In years<br>lost birthday) |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |
| Female   | Cauc                         |   | 1-27-93  |   | 36 YRS.                            |   |   |
| 7a. BIRTHPLACE (State or foreign<br>country)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                 |   | Md.   |
| Maryland   | USA                          |   |  |   | Baltimore                          |   |   |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                                      |                                    | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |
| Baltimore  |                              | Shangra-La Nursing Home,<br>Catoonsville, Md.                                   |  | Unknown   |                                    |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| Maryland   |                              | —   |  | Baltimore   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |   |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET AND NUMBER  |                                    |   |   |
| First Middle Lost  |                              | First Middle Lost   |  | Uplands Apts  |                                    |   |   |
| William  |                              | Kasten  |  | Julia   |                                    | Houch   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |                                    | Address   |   |
| NO   |                              | 212-07-782  |  | Arthur G. Lentner   |                                    | 2107 Southland Rd Balt 21207  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cardiovascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                              |   |  |   |                                    |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>6 days</u><br><u>3 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Anemia Urinary Tract Infection</u>  |                              |   |  |   |                                    |   |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |
|  |                              |   |  |   |                                    |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                    |   |   |
|  |                              |   |  |   |                                    |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                    |   |   |
|  |                              |   |  |   |                                    |   |   |
| 22a. I certify that (U) (this hospital) attended the deceased from <u>9 NOV</u> , 19 <u>68</u> , to <u>April</u> , 19 <u>69</u> , that (U) (we) last<br>saw the deceased alive on <u>14 April</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (U) (we) (did) (did not) view the body after death.   |                              |   |  |   |                                    |   |   |
| 22b. SIGNATURE<br><u>Richard R. Stephenson, MD</u> DEGREE  |                              |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                    | 22c. DATE SIGNED<br><u>14 April 1969</u>  |   |
| 22d. PHYSICIAN'S NAME (Type)   |                              |   |  | 22e. ADDRESS<br><u>1302 Crofton Road Balt. Md 21212</u>   |                                    |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    | 23d. LOCATION (City or Town) (County) (State)   |   |
| Entombment   |                              | 4-17-69   |  | Lorraine Mausoleum  |                                    | Baltimore, Maryland   |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>ARMACOST</u>   |                              |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><u>APR 17 1969</u>   |                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

|   |         |  |                  |   |  |   |   |
|---|---------|--|------------------|---|--|---|---|
| 05087   |         | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |                  |   |  | 05079   |   |
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Last  | 2a. DATE OF DEATH  |   | 2b. HOUR  |
| Alice   |         | L.   |                  | Kearfott  | April <sup>Month</sup> 6 <sup>Day</sup> 1969 <sup>Year</sup> |   | 4:15 M  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years<br>lost birthday)                           |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  |
| Female  | White   |  | 4-26-05          |   | 63 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN                   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |
| Baltimore   |         | USA  |                  |   |  | Baltimore Md.   |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)                                    |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |
| Baltimore   |         | St. Joseph Hospital  |                  | Homemaker   |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| Maryland  |         | Baltimore  |                  |   |  | 13e. STREET AND NUMBER<br>Box 115 Hydes, Maryland   |   |
| 14. FATHER'S NAME   |         | First  | Middle           | Last  | 15. MOTHER'S MAIDEN NAME                                     |   | First Middle Last                               |
| Benjamin Johnson Chamberlein  |         |  |                  |   | Mary Howard  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |  | Address   |   |
| No  |         | 213-20-1303  |                  | M. Munroe Holley  |  | Box 422 Kingsville Md   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |                  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>  |         |  |                  |   |  |   |   |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |         |  |                  |   |  |   |   |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Coronary artery thrombosis</u>   |         |  |                  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |                  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)  |         |  |                  |   |  |   |   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that (X) (this hospital) attended the deceased from 3-25, 1969, to 4-6, 1969, that (X) (we) last<br>saw the deceased alive on 4-6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (X) (we) (did) (did not) view the body after death. |         |  |                  |   |  |   |   |
| 22b. SIGNATURE  |         |  |                  | DEGREE  |  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |         |  |                  | 22e. ADDRESS  |  | 4-7-69  |   |
| Reynaldo Orjuela-Gomez, M.D.  |         |  |                  | 7620 York Road, Towson, Maryland  |  | 21204   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |
| Burial  |         | 4/9/69   |                  | Baltimore National  |  | Baltimore, Maryland   |   |
| 24. FUNERAL DIRECTOR  |         |  |                  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |   |
| Leonard J Ruck Inc  |         |  |                  | Baltimore, Maryland   |  | APR 8 1969  |   |
|   |         |  |                  |   |  | 25b. REGISTRAR'S SIGNATURE  |   |
|   |         |  |                  |   |  | Charles Judge   |   |

05087

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |                                   |  |
|---|--|--|--|--|---|--|--|-----------------------------------|--|
| <div>05088</div> <div>CERTIFICATE OF DEATH</div> <div>05080</div>   |  |  |  |  |   |  |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR                                     |
| MARGARET E KENNEDY  |  |  |  |  |   | APRIL Month Day Year   |  |                                   | 9:38 <sup>AM</sup>                           |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years lost birthday)  |                                   | IF UNDER 1 YEAR MONTHS DAYS                  |
| FEMALE  |  | WHITE  |  | 2-4-1899   |   |  | 70 YRS.  |                                   | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   | Md.  |
| MARYLAND  |  | U.S.A.   |  |  |   | BALTIMORE  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| TOWSON 4  |  |  | ST. JOSEPH HOSPITAL  |  |   | Retired  |  | Telephone operator                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| MARYLAND  |  |  |  |  | BALTIMORE   |  |  |                                   | 6112 MAYWOOD AVE. #21209                     |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |  |  |                                   |  |
| Thomas Donohue  |  |  | Bridgett   |  |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no  |  |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |  | 17. INFORMANT   |  | Address  |                                   |  |
|   |  |  | 219-18-9786  |  | Thomas J. Kennedy, Jr.  |  | same   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |   |  |  |                                   |  |
| IMMEDIATE CAUSE (a) Cardiac arrest and brain damage   |  |  |  |  |   |  |  |                                   |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF Acute extensive myocardial insufficiency  |  |  |  |  |   |  |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |   |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease and diabetes mellitus  |  |  |  |  |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |                                   |  |
| 22a. I certify that (he) (this hospital), attended the deceased from 4-4-69, 1969, to 4-5, 1969, that (we) last saw the deceased alive on 4-5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |  |
| 22b. SIGNATURE Jaime M. Punzalon  |  |  |  |  | DEGREE ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED April 5, 1969   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Jaime M. Punzalon, M.D.  |  |  |  |  | 22e. ADDRESS 7620 York Road, Towson 4, Md.  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |
| burial  |  | 4/8/69   |  | St. Johns Cemetery   |   | Long Green Balto. Md.  |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE APR 9 1969   |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 05089  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |  |   |  | 05081  |  |
| Item 5 Film 412 5/2/69 kk  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| WILLIAM JAMES KILGORE JR.  |  |   |  | 4 Month 26 Day 69 Year  |  | 10:00  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)   |  |
| MALE   |  | WHITE   |  | 1911 February 26, 1917  |  | 58 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| LANCASTER, PA.   |  | U. S. A.  |  | BALTIMORE, Co.  |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |
| TOWSON   |  | GREAT. BALT. MED. CEN.  |  | Supervisor  |  | Advertising  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland   |  | Baltimore   |  | Carney  |  | 9618 Harford Road 21234  |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last   |  |  |  |
| WILLIAM J. KILGORE SR.   |  |   |  | Esther Trout  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Address  |  |  |  |
| No   |  |   |  | Mrs. Thelma M. Kilgore 9618 Harford Road  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC BRONCHOGENIC</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 28, 1969</u> , to <u>APRIL 28, 1969</u> , that (I) (we) last<br>saw the deceased alive on <u>APRIL 26, 1969</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>D. G. Caralis M.D.</u>  |  |   |  | 22c. DATE SIGNED<br>4/26/69   |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Dionyssios G. Caralis, M.D.                           |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial   |  | 4/29/69   |  | Glen Haven Memorial Pk  |  | Glen Burnie, Md. A.A. Co.  |  |
| 24. FUNERAL DIRECTOR<br><u>M. Cully F.H.</u>   |  |   |  | 25a. REC'D BY REGISTRAR<br>APR 29 1969  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. J. Jones</u>   |  |

03082

1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of dates and times. The dates are: 1/1/2020, 2/1/2020, and 3/1/2020. The times are: 10:00 AM, 2:00 PM, and 5:00 PM.

3. The third part of the document is a list of events and activities. The events are: Meeting with John Doe, Meeting with Jane Smith, and Meeting with Bob Johnson. The activities are: Reviewing documents, Discussing plans, and Making decisions.

4. The fourth part of the document is a list of conclusions and recommendations. The conclusions are: The meeting was successful, The plans are good, and The decisions are final. The recommendations are: Follow up on the plans, Keep the decisions, and Contact the participants.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 412 Maryland State Department of Health  
5-14-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05082

05090

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |                         |  |   |  |  |  |  |   |   |  |
|--|-------------------------|--|---|--|--|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ALVA</b>  |                         | First <b>Cletus</b>  |   | Last <b>KINSEY</b>   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>April 11, 1969</b> |  | 2b. HOUR <b>6:45A</b>   |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>March 11, 1923</b>  | 6. AGE (In years last birthday)<br><b>46</b> YRS.                                       | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>   |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>11</b> , Year <b>1969</b>     |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Truck Driver</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing Co.</b>   |  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                         | 13b. COUNTY <b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>1703 W. Hollins Street</b>                             |   |  |
| 14. FATHER'S NAME<br>First <b>Cletus B. Kinsey</b>   |                         |  | Middle <b></b>  |  |  | Last <b></b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Mabel J. Howe</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>216-16-2656</b>  |  |  | 17. INFORMANT<br><b>Family records</b>   |  |   | ADDRESS<br><b></b>                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b><br><b>5718</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |                         |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pulmonary tuberculosis and arteriosclerotic cardiovascular disease</b>  |                         |  |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b></b>  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b></b>                            |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b></b>  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M. <b></b>             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b></b>   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b></b> |  |  | 21f. LOCATION Street or R.F.D. No. <b></b>   |  |   | City or Town <b></b> County <b></b> State <b></b>       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |  |  |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum</b>  |                         |  | EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                               |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |   | 22b. DATE SIGNED<br><b>4/11/69</b>                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>April 15, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b> |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>         |   |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>  |                         |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 18 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. Schuler, Judge</b>                              |   |  |

05030

Class

March 11, 1953

Person

Two - driver

Person (2)

Class 2 - driver

Class 1 - driver

215-11-376 Family records

201

Initial April 17, 1953 Baltimore National Cem. Baltimore, Maryland

John Lewis, Jones, Tobacco, or Iron

1953-1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50501

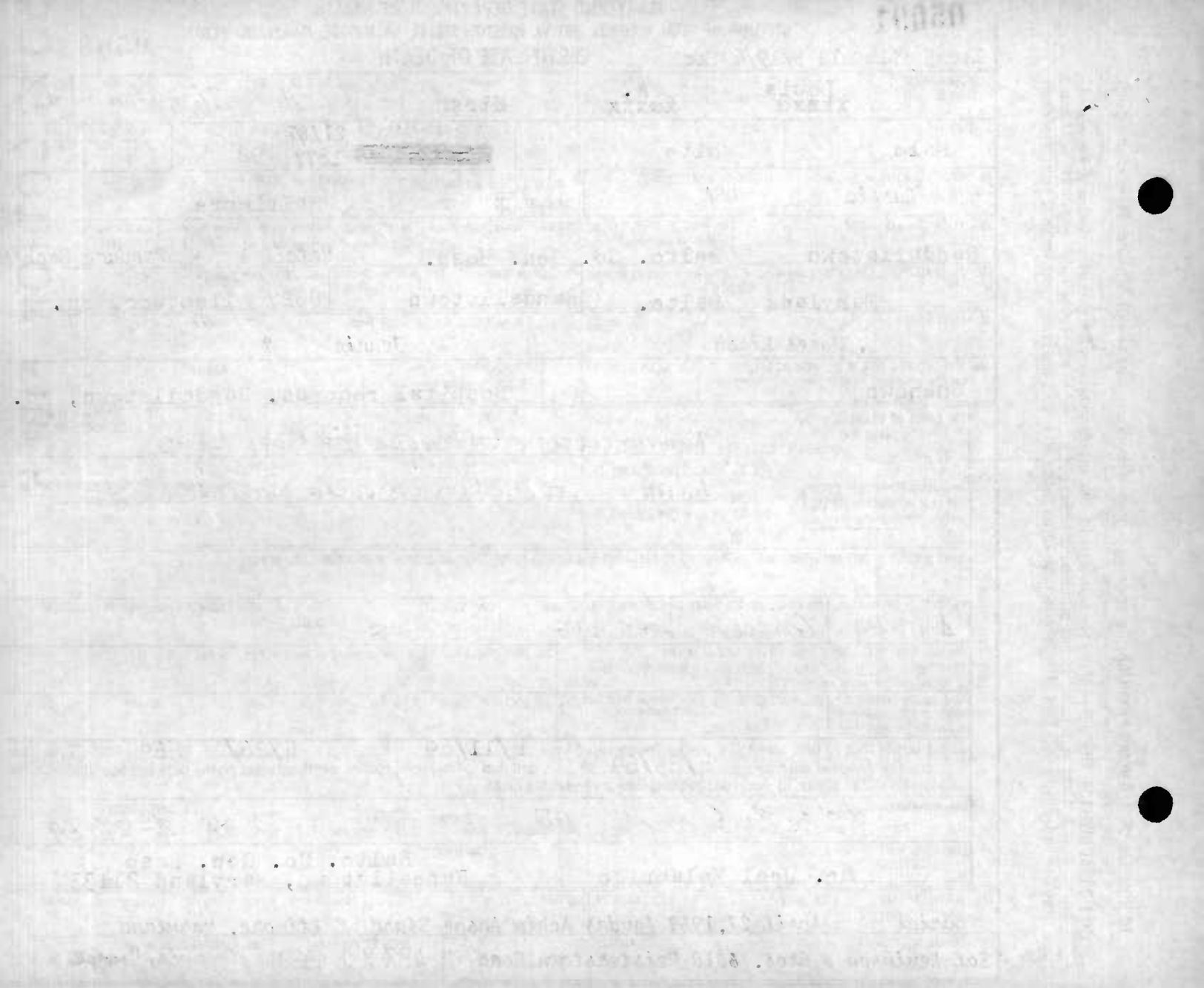
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05083

Item 5 Film 412 5/19/69 kk

# CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Louis Kirsh</b>   |  | Middle <b>A Kirsh</b>  |  | Lost <b>Kirsh</b>   |  | 2a. DATE OF DEATH<br><b>4</b> Month <b>26</b> Day <b>69</b> Year                     |  | 2b. HOUR<br><b>1:30 A M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH <b>MARCH 21/87</b>   |  | 6. AGE (In years last birthday)<br><b>82</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Co. Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retail</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Produce Broker</b>                           |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Randallstown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8827 Allenswood Rd.</b>  |  |
| 14. FATHER'S NAME First Middle Lost<br><b>Moses Kirsh</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Lost<br><b>Jennie ?</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>Unknown</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Hospital records, Randallstown, Md.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC GANGRENE OF BOTH LEGS</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>4-17-69</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GANGRENE, LEFT LEG</b>                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/69</b> , 19 <b>69</b> , to <b>4/26/69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/25/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joel Malabrigo</b>  |  | 22c. DATE SIGNED<br><b>4-26-69</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Joel Malabrigo</b>   |  | 22e. ADDRESS<br><b>Balto. Co. Gen. Hosp<br/>Randallstown, Maryland 21133</b>         |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 27, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Agudas Achim Anshe Sfard</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  | 25a. REC'D BY REGISTRAR<br><b>APR 30 1969</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson &amp; Bros.</b>  |  | ADDRESS<br><b>3010 Reisterstown Road</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |   |  |



FOR STATE  
HEALTH DEPT.

05092

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084

|   |                         |   |  |  |  |  |  |  |  |   |  |
|---|-------------------------|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Melvin</b>   |                         | First <b>L.</b>   |  | Middle <b>L.</b>   |  | Last <b>Kitzmiller Sr.</b>   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <b>4/28</b> Year <b>19</b>  |  | 2b. HOUR <b>9:00</b> AM   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Dec. 8, 1918</b>   |  | 6. AGE (In years last birthday) <b>50</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>   |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>28</b> Year <b>1969</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |                         |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2405 Meadow Road</b>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Foreman-City of Baltimore</b> |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>   |                         |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET AND NUMBER<br><b>2405 Meadow Road</b>                             |  |
| 14. FATHER'S NAME<br><b>Robert L. Kitzmiller</b>  |                         |   |  | First <b>L.</b>  |  | Middle <b>L.</b>   |  | Last <b>L.</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Lillian Berry</b>                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                         |   |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-2040</b>   |  | 17. INFORMANT (Wife)<br><b>Mrs. Catherine Kitzmiller, 2405 Meadow Rd.</b>                  |  |  |  | ADDRESS <b>Dundalk, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 Acute Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |                         |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b></b>   |                         |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b></b>   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b></b>   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH<br><b></b>  |                         |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b></b> P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b></b> |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b></b> |  |  |  | 21f. LOCATION Street or R.F.D. No. <b></b>   |  | City or Town <b></b>   |  | County <b></b> State <b></b>  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Theodore C. Patterson</b>  |                         |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |  | 22b. DATE SIGNED <b>4/30/69</b><br><b>3724 Dundalk Ave.</b><br>ADDRESS (Street, city, town, or county) <b>Dundalk, Md.</b> |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>5/3/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bel Air, Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |   |  |  |  | ADDRESS<br><b></b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                            |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be excluded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05093  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                         | 05085   |  |
|--|--|--|--|--|-------------------------|---|--|
| CERTIFICATE OF DEATH   |  |  |  |  |                         |   |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First  | Middle   | Lost                    | 2a. DATE OF DEATH   |  |
| ELVINA   |  |  |  |  |                         | Month   | Day  |
| Klauberger   |  |  |  |  |                         | Year  | 4 1/2 PM                                     |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                         | 6. AGE (In years lost birthday)   |  |
| Female   |  | White  |  | 1-23-1881  |                         | 88 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. COUNTY OF DEATH  |  |
| Missouri   |  | U.S.A.   |  | Baltimore  |                         | Md.   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |
| Garrison, Md.  |  |  | Foxleigh Nursing Home  |  |                         | Housewife   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN       |   | 13d. INSIDE CITY LIMITS?                     |
| Md.  |  |  | Baltimore  |  | Cockeysville            |   | NO <input type="checkbox"/>                  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO. |   |  |
| -- Summers   |  |  | Unobtainable   |  | D 492-09-4670           |   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  | 17b. SOCIAL SECURITY NO.   |  | 17. INFORMANT           |   |  |
|  |  |  |  |  | Home Records            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |                         |   |  |
| IMMEDIATE CAUSE (a) 4369 Cerebral Vascular Acc. sent   |  |  |  |  |                         |   | 18 hours                                     |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis   |  |  |  |  |                         |   | years  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |                         |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |                         |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                         |   |  |
| Arterio sclerotic Heart Disease  |  |  |  |  |                         |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?  |                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                         |   |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |                         |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                         |   |  |
|  |  |  |  |  |                         |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1967, to April 10, 1969, that (I) (we) last saw the deceased alive on April 10, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                         |   |  |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |                         |   |  |
| David I. Miller  |  |  |  | 4-10-69  |                         |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS   |                         |   |  |
| David I. Miller  |  |  |  | 9015 Reisterstown Rd. Owings Mills Md.   |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                         | 23d. LOCATION (City or Town) (County) (State)   |  |
| Removal  |  | 4/11/69  |  | St. Peters Cemetery  |                         | St. Louis County, Mo.   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |                         | 25b. REGISTRAR'S SIGNATURE  |  |
| The S.H. Hines Co.   |  | 2901 14th ST. N.W.   |  | APR 14 1969  |                         | Charles J. J...   |  |

02093

RECEIVED THE DIRECTOR OF THE BUREAU OF INVESTIGATION

APR 10 1947

RECEIVED

ELIXIA

22

1-23-1947

White

Female

Continued

U.S.A.

Missouri

Continued

Foreign Nursing Home

Garland, Mo.

Bellevue Hospital, St. Louis, Mo.

Continued

Continued

1775-C-400

Continued

RECEIVED THE DIRECTOR OF THE BUREAU OF INVESTIGATION

APR 1 1947



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                                  |  |  |  |  |
|--|--|--|--|--|----------------------------------|--|--|--|--|
| 05094  |  |  |  |  | 05086                            |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  | 2a. DATE OF DEATH Month Day Year |  |  | 2b. HOUR                                     |  |
| MAX KLEINER  |  |  |  |  | APRIL 8, 1969                    |  |  | 12:05 A.M.                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS                  |  |
| MALE   |  | WHITE  |  | 09/16/08   |                                  | 60 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH   |  |  |  |
| POLAND   |  | USA  |  |  |                                  | BALTIMORE  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| RANDALLSTOWN   |  | BALTO. CO. GEN. HOSP.  |  | MERCHANT   |                                  | RETAIL   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md   |  | BALTO  |  | RANDALLSTOWN   |                                  |  |  | 3103 Donna Rd                                |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |                                  |  |  |  |  |
| Benjamin Kleiner   |  |  | BELLA                                      |  |                                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |                                  |  |  |  |  |
| NO   |  |  |  | XXXXX MRS. DOROTHY KLEINER, 3103 DONNA RD. #7  |                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |                                  |  |  |  |  |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION  |  |  |  |  |                                  |  |  | 1 HR   |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                                  |  |  |  |  |
| (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |  |                                  |  |  | 10 X'S                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                  |  |  |  |  |
| (c)  |  |  |  |  |                                  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                                  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |                                  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |                                  | City or Town   |  | County State                                 |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1960, to 4/7, 1969, that (1) (we) last saw the deceased alive on 4/7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE Bernard R. Shochet, MD DEGREE                                 |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |                                  | 22c. DATE SIGNED 4/8/69  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) BERNARD R. SHOCHET  |  | 22e. ADDRESS 6804 PARK HEIGHTS AVE, BALTO-15                                 |  |  |                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 23b. DATE 4-8-69   |  | 23c. NAME OF CEMETERY OR CREMATORY SWINICHER WOLINER BENEVOLENT ASSOC., BALTIMORE, MD.   |                                  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.  |  | 25a. REC'D BY REGISTRAR APR 9 1969   |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |                                  |  |  |  |  |

02004

CHARTERED

EXHIBIT

FILE

EXHIBIT, DONOR, 3125 BROADWAY

BERNARD J. SHOCHET

NOT LITIGANT & LOSS, INC., 801 KENTINGTON  
1-2-50  
EXHIBIT, DONOR, 3125 BROADWAY

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05087

VR A15ME (5)  
10M REV. 1/68

1116-0000 21/001933-5 TRANSPORTATION 420000

05096

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05088

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Mary</i>  |  |  | First Middle Last <i>K. KRAITZ</i>   |  |  | 2a. DATE OF DEATH<br>Month <i>4</i> Day <i>10</i> Year <i>69</i>  |  |  | 2b. HOUR<br><i>3:30 P.M.</i>   |  |  |
| 3. SEX<br><i>Female</i>  |  |  | 4. RACE<br><i>White</i>  |  |  | 5. DATE OF BIRTH<br><i>3/2/1889</i>   |  |  | 6. AGE (In years last birthday)<br><i>80</i> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore Co.</i> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Almacet Nursing Home</i>                            |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Homemaker</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 13e. STREET AND NUMBER<br><i>6012 Loch Raven Blvd.</i>   |  |  | 14. FATHER'S NAME<br>First <i>Henry</i> Middle <i>E. S.</i> Last <i>Wirth</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Anne</i> Middle <i>Wirth</i> Last <i>Wirth</i>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service) <i>---</i>   |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>---</i>   |  |  | 17. INFORMANT<br><i>Mrs. John McQuade, Jr.</i>   |  |  | Address<br><i>941 Ellendale Drive 4</i>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Vulva</i><br><i>1841</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>---</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>---</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>April</i> , 19 <i>69</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>April 1</i> , 19 <i>69</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>did</i> ) ( <i>did not</i> ) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>J. F. Palmisano</i>   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>4-13-69</i>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Joseph F. Palmisano M.D.</i>  |  |  | 22e. ADDRESS<br><i>6608 Loch Raven Blvd.</i>   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>4/14/69</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadow Ridge Mem. Park Cem.</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Mitchell-Wiedefeld Home</i>   |  |  | ADDRESS<br><i>6500 York Rd. 21212</i>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 18 1969</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Jones</i>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

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City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 11-49

|   |  |  |  |  |   |  |  |   |  |
|---|--|--|--|--|---|--|--|---|--|
| 05097   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |  |  |   | 05089  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Mabel E. Krause</b>   |  |  |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 14 1969</b>                                  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>10/30/1892</b>  |   | 6. AGE (In years last birthday)<br><b>76</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Armacost Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Secretary</b>                                      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Roads</b>                                      |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3939 Roland Ave.</b>       |  |
| 14. FATHER'S NAME First Middle Last<br><b>John Jacob Krause</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katie E. Unkelback</b>                                      |  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-1868</b>   |  | 17. INFORMANT Address<br><b>Miss Ruth Lackner, 3311 Woodstock Ave.</b>   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Colon</b><br><b>1951</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis to Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1969</b> to <b>April 14 1969</b> , that (I) (we) saw the deceased alive on <b>April 14 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Laurence C. Post M.D.</b>  |  | 22c. DATE SIGNED<br><b>4/15/69</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Laurence C. Post</b>  |   |  |  |   |  |
| 22e. ADDRESS<br><b>6805 York Road</b>   |  |  |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/17/1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12. Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 17 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |   |  |

105037

CLINICAL OF DEATH

April 11 1969

10/06/1962

Baltimore

Advanced Learning House Baltimore, 3939 Highland Ave.

John Jacob Lawrence  
Hattie E. Unpublished

211-01-1968 1144 West Lochman, 3931 Woodstock Rd.

Dr. Lawrence G. Kent  
6805 York Road

Baltimore

APR 11 1969

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |   |  |
|---|--|--|--|---|---|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |   |  |
| 05098   |  |  |  |   |   |   |  |   |  |
| 05090   |  |  |  |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Charles Middle G. Last Lamley  |   |   | 2a. DATE OF DEATH<br>Month 4 Day 24 Year 69   |  | 2b. HOUR<br>11:30 P. M.                               |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>11/28/90  |   | 6. AGE (In years last birthday)<br>78 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore County Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Spring Grove State Hosp. |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>2683 St. Benedict St.                      |   |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.<br>216-02-2905  |   |   | 17. INFORMANT<br>Address<br>Records-Spring Grove State Hospital                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |   |  |
| IMMEDIATE CAUSE (a) Nephrosclerosis - Uremia  |  |  |  |   |   |   |  |   |  |
| 4122 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |   |   |  |   |  |
| (b) Arteriosclerosis C.V. disease   |  |  |  |   |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |   |  |
| (c) Generalized Arteriosclerosis  |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |   |  |
| Bronchopneumonia, bilateral   |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/25/66, 19__, to __, 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on __, 19__, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>Alberto M. Gutierrez MD   |  |  |  |   | 22c. DATE SIGNED<br>4-24-69   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>ALBERTO M. GUTIERREZ MD   |  |  |  |   | 22e. ADDRESS<br>Spring Grove State Hospital   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/28/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>Witzke, 4101 Edmondson Ave., 21229  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 29 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |   |  |

45082

CRIMINAL DEPT

NAME

DATE

SEX

AGE

HT

WEIGHT

HAIR

EYES

SKIN

COMPLEXION

TEETH

VOICE

REMARKS

James Earl Ray

4/25/68

Serial

1000 2122

45082 1000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <i>ANTHONY</i>  |  |   | First <i>Joseph</i> Middle <i>Joseph</i> Last <i>Lapinski</i>  |  |  | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> <i>Apr 3 1969</i>  |   | 2b. HOUR <i>2:30</i> M   |  |
| 3. SEX <i>Male</i>  |  | 4. RACE <i>White</i>                    |  | 5. DATE OF BIRTH <i>2-11-1884</i>  |  | 6. AGE (In years last birthday) <i>85</i> YRS.  |   | 7c. DATE PRONOUNCED DEAD<br>Month <i>Apr</i> Day <i>3</i> Year <i>1969</i>                   |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Poland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore</i>   |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH <i>White Marsh Md</i>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>910 Alexander Rd</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>   |  |   | 13b. COUNTY <i>BALTO</i>   |  |  | 13c. CITY OR TOWN <i>910 ALEXANDER RD</i>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First <i>Joseph</i> Middle <i>Joseph</i> Last <i>Lapinski</i>   |  |   | 15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Mary</i> Last <i>Mary</i>                       |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>  |  |   | 16b. SOCIAL SECURITY NO. <i>28-05-630</i>  |  |  | 17. INFORMANT ADDRESS <i>Antoinette Lapinski - 910 Alexander Rd</i>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4124</i><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>undetermined</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <i>19</i>                               |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |  |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |   |  |  |
| ACTUAL SIGNATURE <i>John C. Hyde</i>  |  |   | EXAMINER'S NAME (Type) <i>JOHN C. Hyde</i>   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED <i>4-3-69</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   |  |   | 23b. DATE <i>4-7-69</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>HOLY ROSARY CEM.</i> |   | 23d. LOCATION (City or Town) (County) (State) <i>DUNDALK MD</i> |  |  |
| 24. FUNERAL DIRECTOR <i>John M. Wehery Sons Inc.</i>  |  |   |  | ADDRESS <i>401 E. CHESTER</i>  |  | 25a. REC'D BY REGISTRAR <i>APR 7 1969</i>   |   | 25b. REGISTRAR'S SIGNATURE <i>John C. Hyde</i>   |  |





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TO HOSPITAL USE: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05100

05092

|   |  |  |   |   |   |   |  |  |  |  |
|---|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Stephen B. Lating</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>28</b> Year <b>1969</b>  |   |   | 2b. HOUR<br><b>11:50</b><br>a. <b>a.</b> M  |  |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>July 10, 1892</b>  |   | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>carpenter</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>59 Northship Road</b> |  |
| 14. FATHER'S NAME<br>First <b>Stephen</b> Middle <b>Lating</b> Last <b>Boeing</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Boeing</b> Last <b>Boeing</b>                      |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>NO</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-5514A</b>   |   | 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right lower lobe massive</b><br><b>486X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Left lower lobe pneumonia</b> |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>April 8, 1969</b> , to <b>April 28, 1969</b> , that (l) (we) lost the deceased alive on <b>April 28, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (l) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Rafael H. Marin</b>  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-28-69</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rafael H. Marin, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Md. 21228</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/1/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorsey, Md.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Fernal Home Dundalk, Md.</b>   |  |  |   |   | ADDRESS<br><b>Ullrich Fernal Home Dundalk, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>1 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 05101   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 05093  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Thomas George Lawrence</b>   |  |  | 2a. DATE OF DEATH<br><b>April 29, 1969</b> Year |   |  | 2b. HOUR<br><b>3:45</b> M  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>May 18, 1877</b>   |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b>    |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>landscape gardener</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Halethorpe</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Lawrence</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Matilda Smith</b>  |   | 17. INFORMANT<br><b>Maryland Naylor - 145 Wilgate Rd Owings Mills</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>214-14-1482</b>                            |   | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4270</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic pneumonia.</b><br>(c) <b>Myocardial heart failure.</b> |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus.</b>  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1960</b> , to <b>April 29, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.          |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Rafael H. Marin, M.D.</b>  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4/29/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS<br><b>Baltimore, Maryland 21228</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-2-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>Armacost Funeral Chapel-4600 Liberty Hts</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 2 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05102

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|   |  |  |        |   |                             |   |            |   |
|---|--|--|--------|---|-----------------------------|---|------------|---|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  | Middle | Last  | 2a. DATE OF DEATH           |   | 2b. HOUR   |   |
| ANNA  |  | JOSEPHINE  | LE     | BRUN  | April Month 5 Day 1969 Year |   | 11:45 P.M. |   |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH  |                             | 6. AGE (In years last birthday)   |            | IF UNDER 1 YEAR<br>MONTHS DAYS                  |
| Female  |  | White  |        | 5-4-1892  |                             | 76 YRS.   |            | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. COUNTY OF DEATH  |            |   |
| Maryland  |  | USA  |        |   |                             | Baltimore Md.   |            |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |            |   |
| Towson  |  | St. Joseph's Hospital  |        |   |                             |   |            |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            | 13e. STREET AND NUMBER                          |
| Maryland  |  | Baltimore  |        |   |                             |   |            | 7138 Greenwood Rd. 21236                        |
| 14. FATHER'S NAME   |  | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME    |   | First      | Middle Last                                     |
| Frank   |  |  |        | Kalal   | Anna                        |   |            | Kreck   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |                             | Address   |            |   |
| No  |  | 212-10-1146B   |        | Charles E. Le Brun  |                             | 7138 Greenwood Ave 21236  |            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |        |   |                             |   |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infarction of small bowel</u>  |  |  |        |   |                             |   |            |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Portal vein thrombosis</u>   |  |  |        |   |                             |   |            |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |        |   |                             |   |            |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |        |   |                             |   |            |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?   |                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |            |   |
| 4-2-69/4-5-69   |  | Gastropexy - Exp. lap.   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                             |   |            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |   |            |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                             |   |            |   |
|   |  |  |        |   |                             |   |            |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>March 29</u> , 19 <u>69</u> , to <u>April 5</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>April 5</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |        |   |                             |   |            |   |
| 22b. SIGNATURE  |  | DEGREE   |        | ATTENDING PHYS.   |                             | MED. DIRECTOR   |            | STAFF PHYS. <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |        | 22c. DATE SIGNED  |                             |   |            |   |
| Samuel Lee, M.D.  |  | 7620 York Road, Towson, Md. 21204  |        | 4-6-69  |                             |   |            |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                             | 23d. LOCATION (City or Town) (County) (State)   |            |   |
| Burial  |  | 4-9-1969   |        | Gardens of Faith  |                             | Baltimore Co. Md.   |            |   |
| 24. FUNERAL DIRECTOR  |  |  |        | ADDRESS   |                             | 25a. REC'D BY REGISTRAR   |            | 25b. REGISTRAR'S SIGNATURE                      |
| Lassahn Funeral Home  |  |  |        | 7401 Belair Road 21236  |                             | APR 10 1969   |            | <i>W. J. ...</i>                                |

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UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |  |
| 05103   |  |  |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  |
| 05095   |  |  |  |   |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Antionette Lehman n   |  |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 28, 1969   |   |  | 2b. HOUR<br>2:30 P. M.                       |  |
| 3. SEX<br>female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>Jan. 3, 1889  |   | 6. AGE (In years last birthday)<br>80 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Germany  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE STATE HOSP. |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife                            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Pr. Geo.  |  | 13c. CITY OR TOWN<br>Mt. Rainier  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>4200 - 31st Street |  |
| 14. FATHER'S NAME First Middle Last<br>Jacob REINERS  |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Gertrude UNKNOWN  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br>Records: SPRING GROVE STATE HOSPITAL   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, death</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardiovascular Ht. Dis.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis, Generalized, senile.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 mins.<br>5 yrs. +<br>5 yrs. + |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic Brain Syndrome and senility.</u>   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from April 9, 1964, to April 28, 1969, that (we) last saw the deceased alive on April 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i>   |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>4-28-69                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.  |  |  |  |   | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>5-2-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Natl  |   | 23d. LOCATION (City or Town) (County) (State)<br>Arlington Va.                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Dehitt Donaldson</i>   |  |  |  |   | ADDRESS<br>Laurel Md  |   | 25a. REC'D BY REGISTRAR<br>MAY 6 1969                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |

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## CERTIFICATE OF DEATH

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|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ANNE BAKER LEIMBACH</b>   |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>9</b> , Day <b>1969</b> Year |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br><b>August 23, 1895</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Hampton House Apts.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Owner, Dress Shop</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>204 E. Joppa Road</b>               |  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry F. Baker</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Cora Warman</b>        |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>Yes, no, or unknown</b>   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Mr. Herbert J. Leimbach, Jr. Keys. Village of Cross 21210</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Bronchopneumonia.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized arteriosclerosis</b> |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11</b> , 19 <b>68</b> , to <b>4/8</b> , 19 <b>69</b> , that (I) (we) lost the deceased alive on <b>4/8</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jamshid Hamed MD.</b>   |  | 22c. DATE SIGNED<br><b>4/10/69.</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>JAMSHID HAMED MD.</b>  |  | 22e. ADDRESS<br><b>TOWSON 4, MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>Apr. 11, 1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Maryland</b>         |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson,</b>   |  | ADDRESS<br><b>1050 York Road</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 14 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |
| Towson, Maryland 21204   |  |  |   |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL OF ILLINOIS

UNIVERSITY OF ILLINOIS - URBANA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |   |  |  |  |                                    |  |   |  |   |
|--|---|--|--|--|------------------------------------|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   |  |  |  |                                    |  |   |  |   |
| 05105  |   |  |  |  |                                    |  |   |  |   |
| 05097  |   |  |  |  |                                    |  |   |  |   |
| CERTIFICATE OF DEATH   |   |  |  |  |                                    |  |   |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |   |  | First Middle Last  |  |                                    | 2a. DATE OF DEATH  |   |  | 2b. HOUR  |
| Margaret W. Lescekauskas   |   |  |  |  |                                    | April Month 28 Day 1969  |   |  | 850 P. M.   |
| 3. SEX   | F |  | 4. RACE  | W  |                                    | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)                                      | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)  |   | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |   |  |   |
| Lithuania  |   | U. S. A.   |  |  |                                    | Baltimore  |   |  |   |
| 1d. CITY OR TOWN OF DEATH  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |   |
| Catonsville  |   | Shady Nook Nursing Home  |  | Housewife  |                                    |  |   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER   |   |
| Maryland   |   | Anne Arundel   |  | Glen Burnie  |                                    |  |   | 400 Delaware Avenue 21061  |   |
| 14. FATHER'S NAME  |   |  | First Middle Last  |  |                                    | 15. MOTHER'S MAIDEN NAME   |   |  | First Middle Last                                       |
| Unknown  |   |  |  |  |                                    | Unknown  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |                                    | Address  |   | 21061  |   |
| No   |   | 218-01-2245  |  | Emily Glessner   |                                    | 400 Delaware Ave. Glen Burnie  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |  |  |                                    |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 1. DEATH WAS CAUSED BY:   |   |  |  |  |                                    |  |   |  |   |
| IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, recurrent</u>  |   |  |  |  |                                    |  |   |  | 10 days   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CVD</u>   |   |  |  |  |                                    |  |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |   |  |  |  |                                    |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |  |  |  |                                    |  |   |  |   |
| 19a. DATE OF OPERATION   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>68</u> , to <u>4/28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |  |  |                                    |  |   |  |   |
| 22b. SIGNATURE <u>Herbert J. Levickas</u>  |   |  |  |  |                                    | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>4/29/69</u>                                      |   |
| 22d. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>  |   |  |  |  |                                    | 22e. ADDRESS <u>5404 East Drive Baltimore 21227</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town) (County) (State) |  |   |
| Burial   |   |  | 5-2-69   |  | Most Holy Redeemer                 |  | Belair Rd. Baltimore Md.                      |  |   |
| 24. FUNERAL DIRECTOR ADDRESS   |   |  |  |  |                                    | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |   |
| Howard H. Hubbard 4107 Wilkens Ave. 21229  |   |  |  |  |                                    | DATE MAY 1 1969  |   | <u>Charles Judge</u>   |   |

STATE OF TEXAS

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# FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Filing 12  
4/30/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|  |                      |   |  |  |                             |   |  |
|--|----------------------|---|--|--|-----------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>Reuben</i>  |                      | First Middle Lost   |  | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 4-21-1969 |                             | 2b. HOUR 6:30 P.M.  |  |
| 3. SEX <i>Male</i>   | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>MARCH 15, 1909</i>  | 6. AGE (In years last birthday) <i>60</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 19  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>NEW YORK CITY</i>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                             | 9. COUNTY OF DEATH <i>Baltimore</i>   |  |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>   |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>IN AUTOMOBILE IN FRONT OF 7914 SUBET ROAD</i>                                   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CAR DRIVE</i>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY <i>CHAUFFEUR</i>                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>  |                      | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN <i>Randallstown</i>  |                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Lost <i>JACOB LEVENBERG</i>   |                      | 15. MOTHER'S MAIDEN NAME First Middle Lost <i>SARAH ?</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES <i>W.W. II</i>                                  |                             |   |  |
| 16b. SOCIAL SECURITY NO. <i>216-03-4403</i>  |                      | 17. INFORMANT ADDRESS <i>7914 XXXX SUBET ROAD</i>   |  |  |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>955X</i> IMMEDIATE CAUSE (a) <i>Bullet wound (extempl) of head</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Had been depressed at least past 1 month</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Had been depressed at least past 1 month</i> |                      |   |  |  |                             |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                      |   |  |  |                             |   |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |                             | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>4-21-69 6:30-7:00 AM</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                             |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>7914 Subet Rd Baltimore County</i>  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                             |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                 |                      |   |  |  |                             |   |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Robert B. Taylor MD</i>   |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22b. DATE SIGNED <i>4-21-69</i>  |                             |   |  |
|  |                      | ADDRESS (Street, city, town, or county) <i>700 Cathedral St.</i>  |  |  |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>  |                      | 23b. DATE <i>4-22-69</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>BETH EL MEMORIAL PARK</i>  |                             | 23d. LOCATION (City or Town) (County) (State) <i>RANDALLSTOWN, MARYLAND</i>       |  |
| 24. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>   |                      |   |  | 25a. REC'D BY REGISTRAR DATE <i>APR 23 1969</i>  |                             | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items#23a,b,c,d DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Film#G412 5/9/69 vpw 05107 CERTIFICATE OF DEATH

05099

|   |                  |   |                                   |   |  |  |   |  |  |
|---|------------------|---|-----------------------------------|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |                  | First<br>Clinton  | Middle                            | Last<br>Lewis   | 2a. DATE OF DEATH<br>Month Day Year<br>April 26, 1969                                |  | 2b. HOUR<br>12:35<br>a.   |  |  |
| 3. SEX<br>male  | 4. RACE<br>white |   | 5. DATE OF BIRTH<br>Aug. 31, 1901 |   | 6. AGE (In years<br>last birthday)<br>67 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.        |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>New York  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |                                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>salesman  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.   |                  | 13b. CITY OR TOWN<br>Balto.   |                                   | 13c. CITY OR TOWN<br>Gwynn Oak  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>1928 Englewood Avenue    |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Ralph Clayton Lewis   |                  |   |                                   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Nina Hallstead   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |                  | 16b. SOCIAL SECURITY NO.<br>202-01-2954A  |                                   | 17. INFORMANT<br>Address<br>Records: SPRING GROVE STATE HOSPITAL  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death. 10 mins.<br>4109 DUE TO, OR AS A CONSEQUENCE OF with previous myocardial infarc.<br>(b) Arteriosclerotic cardiovascular ht. dis. 10 yrs.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerosis, generalized, senile 10 yrs. |                  |   |                                   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
|   |                  |   |                                   |   |  |  |   |  |  |
|   |                  |   |                                   |   |  |  |   |  |  |
|   |                  |   |                                   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Alcoholism, chronic, 10 yr. history of.  |                  |   |                                   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from March 26, 1969, to April 26, 1969, that (X) (we) last saw the deceased alive on April 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |   |                                   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i><br>DEGREE   |                  |   |                                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4-29-69  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.  |                  |   |                                   | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |  |  |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>removal   |                  | 23b. DATE<br>May 6, 1969  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Anatomy Board of Md.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.                       |   |  |  |
| 24. FUNERAL DIRECTOR<br>Newell Funeral Home, Reisterstown Rd. Md.   |                  |   |                                   | ADDRESS<br>Balto.   |  | 25a. REC'D BY REGISTRAR<br>DATE MAY 6 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05108

CERTIFICATE OF DEATH

05100

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>Lichtenberg, nmi (Burt) BURTON</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>4</b> Year <b>1969</b> |   |  | 2b. HOUR<br><b>30am</b>   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>7-29-27</b>  |  | 6. AGE (In years lost birthday)<br><b>41</b> YRS.   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Norfolk, Va</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto. Co.</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown, Md</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>B.C.G.H.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WHOLESALE</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 13e. STREET AND NUMBER<br><b>6822-C Townbrook Dr.</b>  |  | 14. FATHER'S NAME First <b>A.</b> Middle Last<br><b>Samuel Lichtenberg</b>                      |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Pearl nmi Miller</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-28-3174</b>  |   | 17. INFORMANT<br><b>MR. HERBERT LICHTENBERG</b>   |  | Address<br><b>3421 WASHINGTON AVE.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic lymphosarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>2001 |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. _____ 19____                            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10/63</b> , 19____, to <b>4/3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Milton Schlenoff MD</b>   |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4/4/69</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Milton Schlenoff</b>  |  |   |   | 22e. ADDRESS<br><b>6410 WINDSOR MILL ROAD</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REBURY (Specify)   |  | 23b. DATE<br><b>4-6-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH JACOB</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FINKSBURG, MARYLAND</b>                     |   |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 9 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |              |  |                               |   |  |   |  |
|--|--------------|--|-------------------------------|---|--|---|--|
| 05109  |              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |                               |   |  | 05101   |  |
| 1. DECEASED-NAME<br>(Type or print)  |              | First<br>William   | Middle<br>C.                  | Last<br>Lilly   | 2a. DATE OF DEATH<br>April Month 12, 1969 Year |   | 2b. HOUR<br>3:30 P M                         |
| 3. SEX<br>M  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>1-14-1881 |   | 6. AGE (In years<br>last birthday)<br>88 YRS.  | IF UNDER 1 YEAR<br>MONTHS   | IF UNDER 24 HRS<br>DAYS                      |
| 7a. BIRTHPLACE (State or foreign country)<br>Philadelphia,   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Holly Hill Manor N. H. Ret'd |                               | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Foundryman   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>Maryland STATE  |              | 13b. COUNTY<br>BALTO.  |                               | 13c. CITY OR TOWN<br>Balto. 21212   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>810 Winston Avenue   |              | 14. FATHER'S NAME<br>First William Middle C. Last Lilly  |                               | 15. MOTHER'S MAIDEN NAME<br>First Annetta Middle Irving Last Irving   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |              | 16b. SOCIAL SECURITY NO.<br>043-05-5363A   |                               | 17. INFORMANT<br>Mrs. Charles T. Coard  |  | Address<br>810 Winston Ave  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |              |  |                               |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |              |  |                               |   |  |   |  |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1969   |                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |                               | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1969, to April 12, 1969, that (I) (we) last saw the deceased alive on April 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |              |  |                               |   |  |   |  |
| 22b. SIGNATURE<br>Laurence C. Post M.D.  |              | 22c. DATE SIGNED<br>4/14/69  |                               | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Laurence C. Post   |              | 22e. ADDRESS<br>6805 York Road   |                               |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial Removal  |              | 23b. DATE<br>4-17-69   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>St. Petersburg, Fa.                            |  |
| 24. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.   |              | ADDRESS<br>4905 York Road Balto., Md.  |                               | 25a. REC'D BY REGISTRAR<br>APR 14 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05110

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05102

|   |         |   |                                    |  |  |   |  |  |  |                |  |   |  |
|---|---------|---|------------------------------------|--|--|---|--|--|--|----------------|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |                                    | Middle   |  | Last  |  | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> |  | Month Day Year |  | 2b. HOUR<br>M                                   |  |
| NORMA   |         | EDITH   |                                    | LUCY   |  |   |  |  |  | 19             |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years<br>lost birthday) | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year   |  | 1969           |  | 2d. HOUR<br>5:30 P.M.                           |  |
| female  | white   | 11-26-23  | 45 YRS.                            |  |  |   |  | April 14,  |  |                |  |   |  |
| 70. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH  |  |  |  |                |  | Md.   |  |
| Maryland  |         | U.S.A.  |                                    |  |  | Baltimore   |  |  |  |                |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)         |                                    | 120. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |                |  |   |  |
|   |         | 2902 Michigan Avenue  |                                    | Housewife  |  |   |  |  |  |                |  |   |  |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission to institution)   |         | 13b. COUNTY   |                                    | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                |  |   |  |
| Maryland  |         | Baltimore   |                                    |  |  |   |  | 2902 Michigan Avenue   |  |                |  |   |  |
| 14. FATHER'S NAME   |         | First   |                                    | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First          |  | Middle  |  |
| Joseph  |         | M. Heyler   |                                    |  |  |   |  | Edith  |  | Lindenaena     |  |   |  |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | (If yes give war or dates of service)   |                                    | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |                |  |   |  |
| No  |         |   |                                    | 217-46-3275  |  | Howard W. Lucy  |  | 2902 Michigan Ave.   |  |                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____  |         | 955X  |                                    | Gunshot Wound of Neck  |  |   |  |  |  |                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |         |   |                                    |  |  |   |  |  |  |                |  |   |  |
| 190. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                                    |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |                |  |   |  |
| 210. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR MIN. 4:40 P.M. 4/14 19 69                  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. shot self in <del>HEAD</del> neck   |  |   |  |  |  |                |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>2902 Michigan Avenue, Baltimore, Maryland  |  |   |  |  |  |                |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | ACTUAL<br>SIGNATURE _____<br>EXAMINER'S<br>NAME (Type) Werner U. Spitz, M.D.            |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br>4/15/69   |  |  |  |                |  |   |  |
| 230. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |                                    | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |                |  |   |  |
| Burial  |         | 4/18/69   |                                    | Holy Redeemer  |  | Balt., Md.  |  |  |  |                |  |   |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS   |                                    | 250. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                |  |   |  |
| George L. Schwab  |         | 2101 Frederick Ave.   |                                    | APR 18 1969  |  | Charles Judge   |  |  |  |                |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

|   |  |  |                   |  |   |  |  |  |     |  |
|---|--|--|-------------------|--|---|--|--|--|-----|--|
| 05111   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                   |  |   | 05103  |  |  |     |  |
| Item 10 Film 411 4/23/69 kk   |  |  |                   |  |   |  |  |  |     |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |     |  |
| DOLORES   |  |  | R. LYNCH          |  | Month 12 Day 14 Year 1969   |  | M  |  |     |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH   |   | 6. AGE (If years last birthday)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |     |  |
| Female  |  | White  |                   | April 12, 1915   |   | 54 YRS.  |  | IF UNDER 24 HRS. HOURS MIN.                  |     |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  | Md. |  |
| Maryland  |  | U.S.A.   |                   |  |   | Baltimore County   |  |  |     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |     |  |
| Baltimore   |  | 1523 Clearwood Road  |                   | Housewife  |   | None   |  |  |     |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE   |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |     |  |
| Maryland  |  | Baltimore  |                   |  |   |  |  | 1523 Clearwood Road                          |     |  |
| 14. FATHER'S NAME   |  |  | First Middle Last |  | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last                            |     |  |
| James   |  |  | Shipley           |  | Regina  |  |  | Rose Herrlich                                |     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT  |   | Address  |  |  |     |  |
| No  |  | None   |                   | Walter H. Lynch  |   | 6530 Franklin Road   |  |  |     |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Negative Coma</u>   |  |  |                   |  |   |  |  | 2 wk   |     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitochondrial Carcinoma</u>   |  |  |                   |  |   |  |  | 1 yr   |     |  |
| (c) <u>Breast Carcinoma</u>   |  |  |                   |  |   |  |  | 2 yr   |     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                   |  |   |  |  |  |     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |     |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |     |  |
| 22a. I certify that (1) (this hospital) attended the deceased from July 68, 1968, to Aug 1969, that (2) (we) last saw the deceased alive on 4/10/69, 1969, and that in my (aur) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |                   |  |   |  |  |  |     |  |
| 22b. SIGNATURE <u>Raymond D. Barr</u>   |  |  |                   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 4/16/69   |  |     |  |
| 22d. PHYSICIAN'S NAME (Type) RAYMOND D. BARR  |  |  |                   |  | 22e. ADDRESS 51 Argo Ave  |  |  |  |     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |     |  |
| Burial  |  | 4-19-69  |                   | HAMPSTEAD CEMETERY   |   | Hampstead Carroll Co. Md.  |  |  |     |  |
| 24. FUNERAL DIRECTOR  |  |  |                   |  | 25a. REC'D BY REGISTRAR   |  | 25b. I certify that the deceased was buried in accordance with the provisions of the Public Health Code of Maryland. |  |     |  |
| William E. Johnson 8521 Loch Raven Blvd.  |  |  |                   |  | APR 17 1969   |  |  |  |     |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |                                   |
|---|--|--|--|---|--|--|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |                                   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |                                   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |
| Frank F. Maddox   |  |  |  |   |  | Month Day Year<br>April 10, 1969   |  |  | 1:05 P.M.                         |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR MONTHS DAYS       |
| Male  |  | Negro  |  | May 29, 1900  |  |  | 68 YRS.  |  | IF UNDER 24 HRS. HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> Separated <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |                                   |
| Virginia  |  | USA  |  | Baltimore   |  |  | Md.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Towson  |  |  | St. Joseph Hospital  |   |  | LETITIA L. MARY  |  |  |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER   |  |                                   |
| Maryland  |  |  |  |   | Baltimore  |  | 1500 E. Chase St. #21213   |  |                                   |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |  |                                   |
| First Middle Last<br>FRANK MADDOX LAURA   |  |  |  |   |  |  |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |  |  |                                   |
| NO  |  |  |  |   | DAISY MADDOX 1839 E LAFAYETTE  |  |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |  |                                   |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |  |                                   |
| IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure</u>   |  |  |  |   |  |  |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |  |  |                                   |
| (b) <u>Myocardial Infarction</u>  |  |  |  |   |  |  |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |  |                                   |
| (c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>   |  |  |  |   |  |  |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |  |  |   |  |  |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 14, 1969</u> , to <u>April 10, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 10</u> 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |                                   |
| 22b. SIGNATURE  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |                                   |
| <u>Tomboc</u>   |  |  |  |   |  |  | April 10, 1969   |  |                                   |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS   |  |  |  |                                   |
| Camilo Tomboc, M.D.   |  |  |  |   | 7620 York Road Baltimore, Md. 21204  |  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |                                   |
| BURIAL  |  | 4-15-69  |  | MT-AUBURN   |  |  | BALTIMORE Md   |  |                                   |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |
| JOSEPH KNIGHT 1639 N. BROADWAY, BALTO. Md.  |  |  |  |   | 21213 APR 15 1969  |  | Charles Jones  |  |                                   |

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April 10, 1962

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VR A15  
30M REV. 7-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
|--|--|------------------|---|--|---|---|--|---|---|---|---------------|-------------------------------|------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| 05113  |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| 05105  |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| CERTIFICATE OF DEATH   |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                  | First<br>Anna   |  | Middle<br>Louise  |   | Last<br>Maeser   |   | 2a. DATE OF DEATH<br>4 Month 15 Day 69 <sup>ear</sup>                       |   | 2b. HOUR<br>M |                               |      |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |   |  | 5. DATE OF BIRTH<br>11-21-89 88                                 |   |  | 6. AGE (In years<br>last birthday)<br>80 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  |               | IF UNDER 24 HRS.<br>HOURS MIN |      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Baltimore County Md.                                  |   |               |                               |      |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Co. Gen. Hospital |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life even if retired.)<br>Housewife  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |               |                               |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  |                  | 13b. COUNTY<br>Baltimore  |  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>2419 Pelham Ave.      |               |                               |      |  |
| 14. FATHER'S NAME<br>First<br>William  |  |                  | Middle<br>Becker  |  | Last<br>Elizabeth   |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Schumacher                                      |   |   | Middle<br>known                                 |               |                               | Last |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown) No   |  |                  | (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Dorothy M. Schott - 2419 Pelham Avenue   |   |   |               |                               |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>151.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of the stomach &amp; metastases</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |               |                               |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Fucus plugging of bronchi - pulmonary atelectasis</u>  |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| 19a. DATE OF OPERATION   |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? yes |   |               |                               |      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |               |                               |      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County  |               | State                         |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                  |   |  |   |   |  |   |   |   |               |                               |      |  |
| 22b. SIGNATURE<br>S. M. Call, MD   |  |                  | 22c. DATE SIGNED<br>4-16-69   |  |   | 22d. PHYSICIAN'S<br>NAME (Type)<br>22e. ADDRESS<br>22f. DEGREE<br>22g. MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>       |  |   |   |   |               |                               |      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  | 23b. DATE<br>4-19-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cemetery |   |  | 23d. LOCATION (City or Town)<br>Baltimore, Maryland   |   | (County)<br>(State)                             |               |                               |      |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Road-21206  |  |                  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 22 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |   |               |                               |      |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05106

05114

|  |  |  |   |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>William E. Magill</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>6</b> Year <b>1969</b> |  |  | 2b. HOUR <b>A</b> MIN <b>11:03</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>10-19-1887</b>  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3005 Woodhome Ave. #21234</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>George Magill</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Catherine Young</b>  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes WW I</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-3686</b>   |   | 17. INFORMANT<br><b>Katherine Magill</b>   |  | Address<br><b>Same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary emphysema</b><br><b>4270</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-25</b> , 19 <b>69</b> , to <b>4-6</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. Banderas</b>   |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>4-6-69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. Banderas, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>7620 York Road, Towson, Maryland</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/9/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 8 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 115 21  
30M REV. 1-68

|   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|---|---|--|--|--|--|---------------|--|--|--|
| 05115   |  |  |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |  |  | 05107         |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Carl A. Maneth  |  |  |  |  |  |   |  |  |  | 2a. DATE OF DEATH Month Day Year<br>1 22 1969  |  |  |  |   |   |  |  |  |  | 2b. HOUR<br>M |  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Cau.  |  |  | 5. DATE OF BIRTH<br>5-31-1907   |  |  | 6. AGE (In years last birthday)<br>61 YRS.   |  |  | IF UNDER 1 YEAR MONTHS DAYS                          |  |   | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |               |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Kansas   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Fullerton  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>4139 Oak Hill Ave. |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Body & Fender  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Garage  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Fullerton  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>4139 Oak Hill Avenue 21236 |  |   |   |  |  |  |  |               |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Charles Maneth   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Augusta Zimmer                                       |  |  |   |  |  |  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>212-01-3189  |  |  | 17. INFORMANT Address<br>Mrs Lula E. Maneth 4139 Oak Hill Avenue  |  |  |  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Una fleeter sarcoma</u><br>stating the underlying cause last. (c) <u>undet.</u>   |  |  |  |  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>undet.</u> |   |  |  |  |  |               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-64</u> , 19 <u>64</u> , to <u>4-22</u> , 19 <u>69</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>4-21</u> 19 <u>69</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 22b. SIGNATURE<br><u>John C. Hyle</u>   |  |  |  |  |  |   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |   | 22c. DATE SIGNED<br><u>4-24-69</u>  |  |  |  |  |               |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>JOHN C. HYLE</u>   |  |  |  |  |  |   |  |  |  | 22e. ADDRESS<br><u>7527 Belair Rd Baltimore 21236 Md</u>   |  |  |  |   |   |  |  |  |  |               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  |  |  | 23b. DATE<br><u>4-25-1969</u>  |   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Cemetery</u>   |  |  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Co. Md.</u> |  |  |  |  |               |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home 7401 Belair Road 21236</u>  |  |  |  |  |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 25 1969</u>   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>                        |  |  |  |  |               |  |  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-1969

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |
| BLANCHE   |  | MC   |  | LANE   |  | MANSON   |  | 04 Month 16 Day  |  | 11:00  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |
| FEMALE  |  | CAU  |  | 1-30-12  |  | 57 YRS.  |  | MONTHS   |  | DAYS   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.  |  |  |
| NOVA SCOTIA   |  | U.S.A.   |  |  |  | BALTIMORE CO.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| TOWSON, MD.   |  | GTR. BALTO. MED. CENTER  |  | HOUSEKEEPER + SERVANT  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |
| MD.   |  | A.A. CO.   |  | ANNAPOLIS  |  |  |  | 145 WILLIAMS DR.   |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First  |
|   |  |  |  | MC   |  | LANE   |  | YANK   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |  |
| NO  |  |  |  | THOMAS B. KLAKEING #13   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | DAYS   |
| IMMEDIATE CAUSE (a) LIVER FAILURE   |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |
| 174X METASTATIC CARCINOMA OF LIVER  |  |  |  |  |  |  |  |  |  | SEVERAL MO                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |
| PRIMARY BREAST CANCER   |  |  |  |  |  |  |  |  |  | 6-7 YRS                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |
|   |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town   |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-03, 1969, to 4-16, 1969, that (I) (we) last saw the deceased alive on 4-16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. ADDRESS   |  | 22e. REGISTRAR'S SIGNATURE   |  |  |  |  |
| Richard L. Smith, M.D.  |  | 4-16-69  |  | 6701 NORTH CHARLES STREET  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  | 22f. REGISTRAR'S SIGNATURE   |  | 22g. REGISTRAR'S SIGNATURE   |  |  |  |  |
| RICHARD L. SMITH MD   |  |  |  | 6701 NORTH CHARLES STREET  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |
| BURIAL  |  | 4-21-69  |  | Hillcrest  |  | Annapolis A.A. MD.   |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 24b. ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |
| John M. L. Loxton   |  | Annapolis, Md.   |  | APR 22 1969  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |   |   |   |
|--|--|---|--|---|---|---|---|---|---|
| 05117  |  | CERTIFICATE OF DEATH  |  |   |   |   |   | 05109   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>Annie  |  | Middle<br>M.  |   | Last<br>Marriott  |   | 20. DATE OF DEATH<br>April Month 13 Day 1969 Year |   |
| 3. SEX<br>female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>1892  |   | 6. AGE (In years<br>last birthday)<br>76 YRS.   |   | 2b. HOUR<br>12:30 A M                             |   |
| 70. BIRTHPLACE (State or foreign<br>country)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore   |   | Md.   |   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |  | 120. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>gardner   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |   |
| 130. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>1803 Dover Street       |   |
| 14. FATHER'S NAME<br>First<br>BASIL  |  | Middle<br>CAVEY   |  | Last<br>CAVEY   |   | 15. MOTHER'S MAIDEN NAME<br>First<br>MARGARET   |   | Middle<br>REDMOND                                 |   |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>219-20-7787A  |  | 17. INFORMANT<br>Address<br>Records: SPRING GROVE STATE HOSPITAL  |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION  |  |   |  |   |   |   |   |   |   |
| 190. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 200. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |   |
| 210. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |   | County State                                      |   |
| 220. I certify that (I) (this hospital) attended the deceased from <u>Aug. 16</u> , 19 <u>68</u> , to <u>4/13</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>4/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><u>Dennis D. Agallanos</u>   |  | DEGREE  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |   | 22c. DATE SIGNED<br><u>4/13/69</u>  |   |   |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>DENNIS D. AGALLANOS   |  | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                                    |  |   |   |   |   |   |   |
| 230. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-16-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVE CEMETERY  |   | 23d. LOCATION (City or Town) (County) (State)<br>BANDELLSTOWN MD.                               |   |   |   |
| 24. FUNERAL DIRECTOR<br>WALTERS FUN'L HOME PRATT+STRICKER STS  |  | ADDRESS   |  | 250. REC'D BY REGISTRAR<br>DATE<br>APR 15 1969  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |   |   |

02117

THE OFFICE OF THE

COMMISSIONER

OF THE

STATE

OF NEW YORK

AND

THE

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1917

REPORT

OF THE

COMMISSIONER

OF THE

STATE

OF NEW YORK

FOR THE

YEAR

1916

AND

THE

STATE

OF NEW YORK

FOR THE

YEAR

1916

AND

THE

STATE

OF NEW YORK

FOR THE

YEAR

1916

AND

THE

STATE

OF NEW YORK

APR 12 1917



05118

CERTIFICATE OF DEATH

05110

|   |  |   |   |   |   |  |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>John A. MASON</b>  |  |   | 2a. DATE OF DEATH<br><b>4</b> Month <b>26</b> Day <b>69</b> Year                                      |   |   | 2b. HOUR<br><b>11:15 P.M.</b>  |  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>NEGRO</b>                       |   | 5. DATE OF BIRTH<br><b>12/23/91</b>   |   | 6. AGE (In years last birthday)<br><b>77</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTO.</b>  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>312 LENNAX AVE</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CUSTODIAN</b>                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  |   | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>TOWSON</b>                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>312 LENNAX AVE</b>    |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>MASON</b> Last <b>UNKNOWN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>            |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-20-5035</b>  |   | 17. INFORMANT<br>Address <b>MARIE MASON-312 LENNAX AVE.</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA LUNG</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |   |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> , 19 <b>68</b> , to <b>4-26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-26</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jerome Gaber</b>   |  |   |   |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/28/69</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JEROME GABER</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>5706 BELLONA AV</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5/1/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Rest</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson, Balto. Co. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Chatman Jr. - 1701 Mt. Cyllod St. Balto. Md.</b>  |  |   |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 29 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                             |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02118

STATE OF TEXAS

COUNTY OF DALLAS

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05119

05111

|  |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Catherine A. Masters</i>  |  |  | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>15</i> Year <i>1969</i> |   |   | 2b. HOUR<br><i>4:30</i>   |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>July 28, 1880</i>  |   | 6. AGE (In years last birthday)<br><i>88</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Cape Britton,</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore County,</i> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Canada Catonsville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>29 Darrow Drive</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Cashier</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Hotel</i>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Catonsville</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>29 Darrow Drive</i>  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>-- Mombourquette</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>-- MacDougal</i>   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><i>No</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>077-20-9206</i>                         |   | 17. INFORMANT<br><i>29 Darrow Drive - 21228.</i><br><i>Mrs. Josephine I. McAllister</i> |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br><i>4122</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arter. CVD.</i> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 days</i><br><i>10 days</i><br><i>20 years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Carcinoma, skin of forehead</i>   |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21, 1944</i> , to <i>April 15, 1969</i> , that (I) (we) lost the deceased alive on <i>April 5, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Reeward Gaffe</i>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><i>4/15/69</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Reeward Gaffe</i>   |  |  |  | 22e. ADDRESS<br><i>5501 Forest Park Ave</i>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>April 17, 1969</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery - Baltimore, Md.</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>                          |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Stirling Funeral Estate</i><br><i>736 Edmondson Ave.</i><br><i>Catonsville, Md. 21228</i>   |  |  |  | 25a. REC'D BY REGISTRAR<br><i>APR 17 1969</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |  |

01130

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100-100000-100000  
100-100000-100000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05120

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05112

|  |                     |  |   |   |                                  |  |  |  |   |  |  |
|--|---------------------|--|---|---|----------------------------------|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>JOHN F. MATOSKA</b>   |                     |  | First Middle Last   |   |                                  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year <b>APRIL 20 1969</b>          |  |  | 2b. HOUR <b>11:30</b> M   |  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>12/3/13</b>         | 6. AGE (In years last birthday)<br><b>55</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>21</b> Year <b>69</b>                                      |  |  | 2d. HOUR <b>1230</b> M  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH<br><b>BALTO.</b>  |  |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>  |                     |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3459 YORKWAY</b> |   |                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>BUS DRIVER</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |                     |  | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN <b>DUNDALK</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3459 YORKWAY</b>                                       |  |  |
| 14. FATHER'S NAME<br><b>JOHN MATOSKA</b>   |                     |  | First Middle Last   |   |                                  | 15. MOTHER'S MAIDEN NAME<br><b>BARBARA CECK</b>  |  |  | First Middle Last   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>   |                     |  | (If yes give year or dates of service) <b>WW II</b>   |   |                                  | 16b. SOCIAL SECURITY NO.<br><b>216-01-1332</b>   |  |  | 17. INFORMANT<br><b>MARIE MATOSKA</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HCUD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                     |  |   |   |                                  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                     |  |   |   |                                  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |                                  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>                                    |   |                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                              |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |   |                                  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                     |  |   |   |                                  |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Theo C Patterson</b>  |                     |  | M.D.  |   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED<br><b>4/22/69</b>  |  |  |
| EXAMINER'S NAME (Type)<br><b>THEO C PATTERSON</b>  |                     |  |   |   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |  |  |
|  |                     |  |   |   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |   |  |  |
|  |                     |  |   |   |                                  | ADDRESS (Street, city, town, or county)  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                     |  | 23b. DATE<br><b>4/24/69</b>   |   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>  |                     |  |   |   |                                  | ADDRESS<br><b>300 MACE</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 24 1969</b>                                  |  |  |
|  |                     |  |   |   |                                  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. Charles Under...</b>                            |  |  |



02120

MINI-TRANSPORTS COMPANY OF DENVER

26th F. W. 1974

BA TO DENVER 10:00 AM  
24th F. W. 1974

24th F. W. 1974

24th F. W. 1974

24th F. W. 1974

24th F. W. 1974

24th F. W. 1974



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|---|--|---|---|--|--|----------------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 05121   |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 05113   |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>ANTHONY  |  |  | Middle<br>C.  |  |  | Last<br>MAZUREK   |   |  | 2a. DATE OF DEATH<br>4 Month 4 Day 69 year                              |   |  | 2b. HOUR<br>5 <sup>20</sup> a <sup>m</sup> |                            |  |  |  |  |  |
| 3. SEX<br>MALE  |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>FEBRUARY 12, 1920   |  |  | 6. AGE (In years<br>last birthday)<br>49 YRS.   |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                               |   |  | IF UNDER 24 HRS.                           |                            |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE Co. Md.   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GREAT. BALT. MED. CEN. |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>AGENT   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>INSURANCE   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br>1820 Putty Hill Road                          |   |  |  |                            |  |  |  |  |  |
| 14. FATHER'S NAME<br>First<br>Marcel  |  |  | Middle<br>J.  |  |  | Last<br>Mazurek   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Martha   |   |  | Middle<br>--  |   |  | Last<br>Walinski                           |                            |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes  |  |  | (If yes give year or dates of service)<br>WWII  |  |  | 16b. SOCIAL SECURITY NO.<br>212-01-7127   |  |  | 17. INFORMANT<br>Marguerite H. Mazurek 1820 Putty Hill Rd.                                      |   |  |   |   |  |  |                            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE CARDIAC FAILURE</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>M. INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |   |  |  |                            |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |  |                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>MARCH 31, 1969</u> , to <u>APRIL 4, 1969</u> , that (I) (we) last<br>saw the deceased alive on <u>APRIL 4, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) (did) (did not) view the body after death.                             |  |  |   |  |  |   |  |  |   |   |  |   |   |  |  |                            |  |  |  |  |  |
| 22b. SIGNATURE<br>M.N. Al-Mumayez   |  |  |   |  |  |   |  |  |   | DEGREE<br>ATTENDING<br>PHYS.                    |  |   | <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>4/5/69 |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>DR. M.N. AL-MUMAYEZ M.D.   |  |  |   |  |  |   |  |  |   | 22e. ADDRESS<br>6701 N. CHARLES ST. 21204       |  |   |   |  |  |                            |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>4-7-69   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cem.   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |   |  |   |   |  |  |                            |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Wm. E. Johnson 8521 Loch Raven Blvd. 21204   |  |  |   |  |  |   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 7 1969      |  |   | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |  |                            |  |  |  |  |  |

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EAPR 1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
05122 CERTIFICATE OF DEATH 05114

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Gertrude Mooney McFee  |   |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 5 69  |  | 2b. HOUR<br>6.30 PM                          |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>12-25-1896  |  | 6. AGE (In years last birthday)<br>74 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      | 13e. STREET AND NUMBER<br>16 Aigburth Rd., -21204                                    |  |
| 14. FATHER'S NAME First Middle Last<br>James J. Mooney  |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary O'Leary   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>no   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Janet Galvin 300 Cedarcroft Rd. 12<br>Mr. Robt. A. McFee       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>492X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor Pulmonale<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emphysema |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/31/1969, to 4/5/1969, that (I) (we) last saw the deceased alive on 4/5/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br>Gualberto Gokim Jr.   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4-5-69   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Gualberto Gokim Jr. M.D.  |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |   | 23b. DATE<br>4/9/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cathedral Cemetery                             |  |
| 23d. LOCATION (City or Town) (County) (State)<br>Balto. Md.   |   | 23e. REC'D BY REGISTRAR<br>DATE APR 11 1969   |  |  |  |
| 23f. REGISTRAR'S SIGNATURE<br>John J. Jones   |   | 23g. REGISTRAR'S SIGNATURE  |  |  |  |

02125

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05123

CERTIFICATE OF DEATH

05115

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>CLARENCE B. MILLER</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 5, 1969</b>          |   |   | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>caucasian</b>  |  | 5. DATE OF BIRTH<br><b>Feb. 25, 1876.</b>   |   | 6. AGE (In years last birthday)<br><b>93</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1319 Highland Drive</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret. Engineer PRR</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1319 Highland Drive</b>             |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William E. Miller</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Sarepta Gore</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>A-123239</b>                      |  | 17. INFORMANT<br>Address<br><b>Mrs. Dorothy R. Capparelli (Same)</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>viral gastroenteritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Gus Britsas</b>   |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED<br><b>4/5/69</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Gus Britsas</b>   |  |  |  | 22e. ADDRESS<br><b>6017 Alta Avenue, Balto, Md.</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/8/69.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hereford Baptist Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hereford, Md.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. - Balto, Md. - 14</b>   |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |

05153

STATION

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NO.

Dr. G. H. H. H.

Dr. G. H. H. H.

1961



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| <div>05124</div> <div>05116</div>   |  |   |  |   |  |  |  |  |  |   |  |
| <div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>EMILY KNIGHT MILLER</div>   |  |   |  |   |  |  |  |  |  |   |  |
| <div>2a. DATE KNOWN OF DEATH</div> <div>ESTIMATED</div> <div>Month Day Year</div> <div>APR 23 1969</div>  |  | <div>2b. HOUR</div> <div>11 30</div>  |  | <div>3. SEX</div> <div>F</div>  |  | <div>4. RACE</div> <div>W</div>  |  | <div>5. DATE OF BIRTH</div> <div>7-19-15</div>   |  | <div>6. AGE (In years last birthday)</div> <div>53 YRS.</div> |  |
| <div>7a. BIRTHPLACE (State or foreign country)</div> <div>MD</div>  |  | <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>  |  | <div>8. MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div>   |  | <div>9. COUNTY OF DEATH</div> <div>BALTIMORE</div>                                   |  |  |  |   |  |
| <div>10. CITY OR TOWN OF DEATH</div> <div>COCKEYSVILLE</div>  |  | <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>250 ASHLAND AVE.</div> |  | <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>HOUSEWIFE</div>                                       |  | <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>OWN HOME</div>                     |  |  |  |   |  |
| <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>MD</div>  |  | <div>13b. COUNTY</div> <div>BALTO.</div>  |  | <div>13c. CITY OR TOWN</div> <div>COCKEYSVILLE</div>  |  | <div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div>                     |  | <div>13e. STREET AND NUMBER</div> <div>250 ASHLAND AVE.</div>  |  |   |  |
| <div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>ROBERT HENRY RILEY</div>   |  | <div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>ANNIE (NMN) FOWLER</div>                      |  | <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>NO</div>   |  | <div>16b. SOCIAL SECURITY NO.</div> <div>NONE</div>                                  |  | <div>17. INFORMANT</div> <div>ADDRESS</div> <div>MRS. SARAH BLIZZARD 10 FAIRMOUNT RD. HAMPSHIRE, MD. 21074</div> |  |   |  |
| <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) 4380 HYPERTENSIVE CEREBROVASCULAR DISEASE</div> <div>DU TO, OR AS A CONSEQUENCE OF</div> <div>(b) _____</div> <div>DU TO, OR AS A CONSEQUENCE OF</div> <div>(c) _____</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> |  |   |  |   |  |  |  |  |  |   |  |
| <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>BRONCHIAL ASTHMA</div>   |  |   |  |   |  |  |  |  |  |   |  |
| <div>19a. DATE OF OPERATION</div>   |  | <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div>  |  |   |  | <div>20. AUTOPSY?</div> <div>YES</div> <div>NO</div>                                 |  |  |  |   |  |
| <div>21a. EXTERNAL CAUSE WAS PRIMARY</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div>   |  | <div>21b. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>19</div>  |  | <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>  |  |  |  |  |  |   |  |
| <div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK</div> <div>NOT WHILE AT WORK</div>   |  | <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div>                             |  | <div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>   |  |  |  |  |  |   |  |
| <div>22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div>   |  |   |  |   |  |  |  |  |  |   |  |
| <div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div>   |  | <div>WILLIAM A. PINEBURY</div> <div>M.D.</div>  |  | <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> <div>ADDRESS (Street, City, Town, or County)</div> |  | <div>22b. DATE SIGNED</div> <div>4-24-69</div>                                       |  |  |  |   |  |
| <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div>  |  | <div>23b. DATE</div> <div>4-28-69</div>   |  | <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>BEL AIR MEMORIAL GARDENS</div>   |  | <div>23d. LOCATION (City or Town) (County) (State)</div> <div>BEL AIR MARYLAND</div> |  |  |  |   |  |
| <div>24. FUNERAL DIRECTOR</div> <div>Wm. COOK-BROOKS TOWSON, INC.</div>   |  | <div>ADDRESS</div> <div>1050 YORK RD. TOWSON, MD. 21204</div>   |  | <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>APR 25 1969</div>   |  | <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>                       |  |  |  |   |  |

02154

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

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U.S. DISTRICT COURT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |  |  |   |  |  |  |           |  |
|--|--|---|--|--|--|---|--|--|--|-----------|--|
| 05125  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  | 05117   |  | AM   |  |           |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |           |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | 2. DATE OF DEATH   |  |  | 3. HOUR   |  |  | 4. MIN.  |           |  |
| MILLER   |  |   | JAMES PERKINS  |  |  | 04  |  |  | 09   |           |  |
| 3. SEX   |  |   | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years last birthday)  |           |  |
| MALE   |  |   | CAU  |  |  | APRIL 5, 1921   |  |  | 48 YRS.  |           |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |   | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |           |  |
| MARYLAND   |  |   | U.S.A.   |  |  |   |  |  | BALTIMORE CO.  |           |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |           |  |
| BOWSON, MD.  |  |   | GBMC 6701 N. CHARLES   |  |  | TRUCK DRIVER  |  |  | FREIGHT  |           |  |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |           |  |
| MD.  |  |   | BALTIMORE  |  |  | BALTIMORE   |  |  | YES  |           |  |
| 14. FATHER'S NAME First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |  |  |           |  |
| HERBERT MILLER   |  |   | LENA EYRING  |  |  |   |  |  |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  | Address  |           |  |
| YES  |  |   | W.W.H.   |  |  | 217-03-2683 MARGARET MILLER   |  |  | 403 So. CALHOUN ST.  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |           |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  | 1 MONTH                                      |  |           |  |
| IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE   |  |   |  |  |  |   |  |  |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |  |  |           |  |
| (b) BRAIN METASTASIS OF LUNG CANCER  |  |   |  |  |  |   |  |  |  | 16 MONTHS |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |  |  |           |  |
| (c)  |  |   |  |  |  |   |  |  |  |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |  |  |           |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                            |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |           |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-08, 1969, to 4-09, 1969, that (I) (we) last saw the deceased alive on 4-09-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |           |  |
| 22b. SIGNATURE   |  |   |  |  |  | 22c. DATE SIGNED  |  |  |  |           |  |
| B.R. Choi M.D.   |  |   |  |  |  | 4-9-69  |  |  |  |           |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  |  |  | 22e. ADDRESS  |  |  |  |           |  |
| B.R. CHOI  |  |   |  |  |  | 6701 NORTH CHARLES STREET   |  |  |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)  |           |  |
| BURIAL   |  |   | APR. 12, 1969  |  |  | MEADOWRIDGE CEMETERY  |  |  | HOWARD COUNTY MD.  |           |  |
| 24. FUNERAL DIRECTOR   |  |   |  |  |  | 25a. REC'D BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |           |  |
| WALTERS FUN'L HOME PRATT+STRIKER STS.  |  |   |  |  |  | APR 11 1969   |  |  | J. Charles Underhill   |           |  |

05152

UNITED STATES DEPARTMENT OF STATE

OFFICE OF THE SECRETARY OF STATE

WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |   |  |                  |  |
|--|--|--|--|--|---|--|---|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |   |  |                  |  |
| 05126  |  |  |  |  | 05118   |  |   |  |                  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR                                     |                  |  |
| First Middle Last  |  |  |  |  | Month Day Year  |  |   | M  |                  |  |
| Robert John Miller Sr.   |  |  |  |  | April 12 1969   |  |   |  |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR                              |                  |  |
| Male   |  | White  |  | Sept. 7 1914   |   | 54 YRS.  |   | MONTHS DAYS HOURS MIN.                       |                  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |  |                  |  |
| Balto. Md.   |  | U.S.A.   |  |  |   | Baltimore Md.  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |                  |  |
| Parkville  |  | 3043 Woodside Ave.   |  | Meat Cutter  |   | A&P  |   |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                       |                  |  |
| Maryland   |  | Balto.   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 3043 Woodside Ave.                           |                  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                          |  |   |  |                  |  |
| Frederick H. C. Miller   |  |  |  |  | Minnie Spielman   |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |  | 17. INFORMANT Address  |   |  |   |  |                  |  |
| No   |  | 212-07-4754  |  | Mrs. Ruth E. Miller 3043 Woodside Ave.   |   |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |   |  |                  |  |
| IMMEDIATE CAUSE (a) <u>INANITION</u>   |  |  |  |  |   |  |   | 2 MONTHS                                     |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |   |  |   |  |                  |  |
| (b) <u>ABDOMINAL CARCINOMATOSIS</u>  |  |  |  |  |   |  |   | 5 MONTHS                                     |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |  |                  |  |
| (c) <u>COLON CARCINOMA</u>   |  |  |  |  |   |  |   | 9-12 MONTHS                                  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |  |  |  |  |   |  |   |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                  |  |
| 11-4-1968  |  | COLON OBSTRUCTION  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |   |  |   |  |                  |  |
|  |  |  |  |  |   |  |   |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |   | County State                                 |                  |  |
|  |  |  |  |  |   |  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 4, 1968</u> , to <u>APRIL 9, 1969</u> , that (I) (we) lost saw the deceased alive on <u>April 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |  |                  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED |  |
| Michael K. Finegan   |  |  |  |  |   |  |   |  | April 13 1969    |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |  |   |  |                  |  |
| MICHAEL K. FINEGAN   |  |  |  |  | 111 W. Monument St. 21201   |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)   |   | (County) (State)                             |                  |  |
| Burial   |  | 4-16-69  |  | Parkwood Cem.  |   | Balto. Md.   |   |  |                  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE  |  |                  |  |
| Lassahn H 7401 Belair Rd.  |  |  |  |  | APR 16 1969   |  | Charles Judge   |  |                  |  |

02150

DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY OF HEALTH

REPORT OF THE SECRETARY OF HEALTH

FOR THE YEAR 1900

AND FOR THE YEAR 1901

AND FOR THE YEAR 1902

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AND FOR THE YEAR 1916

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AND FOR THE YEAR 1918



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05127

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05119

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Rose Lee Miller</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 25 1969</b> |   | 2b. HOUR<br><b>12:20 P.M.</b>                                    |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>12-20-20</b>   |   | 6. AGE (In years last birthday)<br><b>48</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore Co.</b> Md.              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. County General</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SECRETARY</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>                          | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>6001 Highgate Dr.</b>               |
| 14. FATHER'S NAME First Middle Last<br><b>SAMUEL KARFUNKEL</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>HELEN HECHT</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>MR. SAMUEL S. MILLER, 6001 HIGHGATE DR. #15</b>                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA LIVER, METASTATIC</b><br><b>1978</b> DUE TO, OR AS A CONSEQUENCE OF <b>PRIMARY SITE NOT DETERMINED</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 3, 1969</b> , to <b>APRIL 25, 1969</b> , that (I) (we) last saw the deceased alive on <b>APRIL 25, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Fausto Q. Aquino, Jr.</b>  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>4-25-69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>FAUSTO Q. AQUINO, JR.</b>  |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSP.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>4-27-69</b>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                                   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 30 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05128   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 05120  |  |  |  |  |                                |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |   |  |  |  |  | 2b. HOUR                                     |  |  |  |  |                                |  |  |  |  |
| First Middle Last<br>WILLIAM H. MILLER  |  |  |  |  |   |  |  |  |  | Month Day Year<br>APR. 11 1969  |  |  |  |  |   |  |  |  |  | M  |  |  |  |  |                                |  |  |  |  |
| 3. SEX<br>M   |  |  |  |  | 4. RACE<br>W  |  |  |  |  | 5. DATE OF BIRTH<br>NOV. 18, 1919   |  |  |  |  | 6. AGE (In years lost birthday)<br>49 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MD.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>BALTO.  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ESSEX  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>TERRACE<br>SEDEGWATER |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CARPENTER  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |  |  |  |  | 13b. COUNTY<br>BALTO  |  |  |  |  | 13c. CITY OR TOWN<br>ESSEX  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |  |  | 13e. STREET AND NUMBER<br>SEDEGWATER TERRACE |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>WM. H. MILLER SR.  |  |  |  |  |   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>EVA KERNER  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>YES WW II   |  |  |  |  |   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-16-7675   |  |  |  |  | 17. INFORMANT<br>LOIS MILLER  |  |  |  |  |  |  |  |  |  | Address<br>A BOVE              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10, 1966, to 4/11, 1969 that (I) (we) last saw the deceased alive on 4/11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE<br>A. Lewis Kolodny, M.D.  |  |  |  |  |   |  |  |  |  | DEGREE<br>M.D.  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br>4/14/69                  |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>A. LEWIS KOLONNY, M.D.  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>1825 Eastern Blvd - 21221   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  |  | 23b. DATE<br>4/14/69  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO MD   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>J.G. CONNELLY SONS  |  |  |  |  |   |  |  |  |  | ADDRESS<br>300 MACE   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 16 1969  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>K. M. M. M.    |  |  |  |  |                                |  |  |  |  |

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UNRECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05129

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05121

|   |  |                         |  |                                     |  |   |  |   |   |  |  |   |  |  |
|---|--|-------------------------|--|-------------------------------------|--|---|--|---|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Laura E Monks</b>  |  |                         | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>7</b> Year <b>69</b>  |                                     |  | 2b. HOUR<br><b>7:30 PM</b>  |  |   |   |  |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br><b>10-15-88</b> |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS <b>16</b> |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>GLEN ARM, Md</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON Md.</b>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Towson Nursing Home</b> |                                     |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DWY HOME</b>  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>  |  |                         | 13b. COUNTY<br><b>BALTO</b>  |                                     |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>251-A Rodger Forge Rd.</b>   |  |  |
| 14. FATHER'S NAME<br>First <b>BENJAMIN</b> Middle <b>SNYDER</b> Last <b>ELIZABETH</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>First <b>ELIZABETH</b> Middle <b>WIRSING</b> Last <b>WIRSING</b>               |                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-54-0941</b>  |  |  | 17. INFORMANT<br>Address <b>MISS R. IRMA MONKS (SAME)</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CEREBRAL ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                         |  |                                     |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 WEEKS</b><br><b>3 YEARS</b> |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                         |  |                                     |  |   |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1968</b> , to <b>APRIL 1969</b> , that (I) (we) last saw the deceased alive on <b>MARCH 31, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                         |  |                                     |  |   |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Arthur Karguin MD</b>  |  |                         |  |                                     |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |   | 22c. DATE SIGNED<br><b>4/2/69</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>ARTHUR KARGUIN MD</b>   |  |                         |  |                                     |  | 22e. ADDRESS<br><b>1532 HAVENWOOD RD.</b>   |  |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>April 4, 1969</b>  |                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Immanuel Lutheran</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Grindon Lane, Md.</b>                       |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>   |  |                         |  |                                     |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 2 1969</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05130   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 05122  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item 13 Film G412 4/30/69 kk  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First<br><b>Lou</b>  |  |  |  |  | Middle<br><b>Ella</b>   |  |  |  |  | Last<br><b>Moser</b>   |  |  |  |  | 2a. DATE OF DEATH<br>Month<br><b>April</b> Day<br><b>14</b> Year<br><b>1969</b>  |  |  |  |  | 2b. HOUR<br><b>8:30</b> MIN.<br><b>a.</b>                               |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>female</b>   |  |  |  |  | 4. RACE<br><b>white</b>  |  |  |  |  | 5. DATE OF BIRTH<br><b>Oct. 3, 1891</b>   |  |  |  |  | 6. AGE (In years<br>lost birthday)<br><b>77</b> YRS.                                   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>77</b> DAYS<br><b>77</b> HOURS<br><b>77</b> MIN.   |  |  |  |  | IF UNDER 24 HRS.<br>HOURS<br><b>77</b> MIN.<br><b>77</b>                |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Va.</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MD. Va.</b>  |  |  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  |  |  | 13c. CITY OR TOWN<br><b>Chilhowie</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 13e. STREET AND NUMBER<br><b>Route #2</b><br><b>Masonic Home / Cockeysville</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First<br><b>Thomas</b> Middle<br><b>Widner</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Belle</b>  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>226-48-6924A</b>  |  |  |  |  | 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right-sided pneumonia</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Pleural effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 3, 1968</b> , to <b>April 14, 1969</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>April 14, 1969</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Diomidis L. Pirovolidis</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | DEGREE<br><b>M.D.</b>  |  |  |  |  | ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br><b>4-14-69</b>                                      |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Diomidis Pirovolidis, M.D.</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL</b><br><b>Baltimore, Maryland 21228</b> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Apr. 17, 1969</b>  |  |  |  |  | 23b. DATE<br><b>Apr. 17, 1969</b>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. View</b>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>R.F.D. Marion, Smyth, Va.</b>      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Reynolds, Marvin</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 22 1969</b>                                  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Reynolds Judge</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

05130

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05131

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05123

|   |         |                              |  |  |                  |  |  |  |  |  |  |
|---|---------|------------------------------|--|--|------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |                  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year |  |  | 2b. HOUR OF DAY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |  |
| MARK V MOUDRY   |         |                              |  |  |                  |  |  |  |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  |  | 2d. HOUR OF DAY  |  |  |
| MALE  | W       | 5-3-1953                     | 15 YRS.  | MONTHS   | DAYS             | April Day 28 Year 1969   |  |  | 4 PM   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH   |  |  |  |  |  |
| Maryland  |         | USA                          |  |  |                  | Baltimore Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Glenarm   |         |                              | NOTH CLIFF RL  |  |                  | Student  |  |  | School   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  |                  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |
| Md  |         |                              | BALTO  |  |                  | Glenarm  |  |  | 8709 Littlewood Rd   |  |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |                  |  |  |  |  |  |  |
| Richard F Moudry  |         |                              | Julie M DOUSA  |  |                  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |  |                  | 17. INFORMANT  |  |  | ADDRESS  |  |  |
| No  |         |                              |  |  |                  | Father   |  |  | Same   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |         |                              |  |  |                  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Multiple Contusions of Skull-Fracture of Neck   |         |                              |  |  |                  |  |  |  |  | Sudden                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and partial to complete Strangulation  |         |                              |  |  |                  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |         |                              |  |  |                  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH  |         |                              |  | 21b. TIME OF INJURY Month, Day, Year   |                  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
|   |         |                              |  | April 28 69  |                  |  |  | Thrown clear of car into stream car  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town State                            |  |  |  |
|   |         |                              |  | Street   |                  |  |  | NOTH CLIFF Rd - Glenarm Md   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |         |                              |  |  |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |
| EXAMINER'S NAME (Type)  |         |                              |  |  |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |
| CHARLES F. O'DONNELL  |         |                              |  |  |                  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |
|   |         |                              |  |  |                  | ADDRESS (Street, city, town, or county)  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              |  | 23b. DATE  |                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |
| BURIAL  |         |                              |  | 5-1-1969   |                  |  |  | PARKWOOD   |  |  |  |
| 24. FUNERAL DIRECTOR  |         |                              |  | 25a. REC'D BY REGISTRAR  |                  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| CHAS. F. EVANS & Son  |         |                              |  | 8802 Parkwood Rd   |                  |  |  | APR 30 1969  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |      |  |  |
|--|--|--|--|--|------|--|--|
| 05132  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |      | 05124  |  |
| Item 23 Film 16 9/11/69 kk   |  | CERTIFICATE OF DEATH   |  |  |      |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle   | Lost | 2a. DATE OF DEATH<br>Month Day Year  |  |
| ANNA B. MOULTON  |  |  |  |  |      | April 29th, 1969   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |      | 6. AGE (In years lost birthday)  |  |
| Female   |  | White  |  | December 8, 1885   |      | 83 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH   |  |
| Maryland   |  | USA  |  |  |      | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Anneslie, Balto. Co.   |  | Armacost Nursing Home  |  | Homemaker  |      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland   |  | Baltimore  |  |  |      | 13e. STREET AND NUMBER   |  |
|  |  |  |  |  |      | 516 Anneslie Rd.   |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   | Lost | 15. MOTHER'S MAIDEN NAME   |  |
| Morris Brown   |  |  |  |  |      | Margaret Crowley   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |      | Address  |  |
| no   |  |  |  | Mrs. Gertrude Quigley  |      | 4206 Roland Ave  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Left Lung</u><br>1621<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.O. No. City or Town County State   |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 4, 1969, to April 29, 1969, that (I) (we) last saw the deceased alive on April 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |  |  |  |      |  |  |
| 22b. SIGNATURE<br>Lawrence Post, M.D.  |  |  |  | 22c. DATE SIGNED<br>4/30/69  |      | 22d. PHYSICIAN'S NAME (Type)   |  |
| 22e. ADDRESS<br>6805 York Rd.  |  |  |  |  |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>May 1, 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial   |  | 4/30/69  |  | Loudon Park Cem.   |      | Balto.   |  |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home-6500 York Rd. 21212  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAY 6 1969  |      | 25b. REGISTRAR'S SIGNATURE   |  |



05139

Wm. B. Landon

April 20, 1960

December 8, 1955

White

Female

Religion

Wm.

Female

Married, White, M., Unemployed, living alone, in mother

to mother, 10

White

Female

Married, living

Married, living

Married, living, 10

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living

Married, living, 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 05133   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                        |   |   |  | 05125  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Amy Gertrude Munroe  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>4 21 1969                |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>May 18, 1875  |  | 6. AGE (In years last birthday)<br>93 YRS.                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Anneslie   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Armocost Nur. Home |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>706 Kingston Rd.                           |  |
| 14. FATHER'S NAME<br>First Middle Last<br>George T Parrish  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Sarah E. Byers |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216 46 7250  |   | 17. INFORMANT<br>Address<br>Mrs Ernest P. Benseler 706 Kingston Rd  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Supernatural Age</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 6, 1960, to April 21, 1969, that (I) (we) last saw the deceased alive on 4-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Thomas G. Abbott  |  |  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Thomas G. Abbott  |  | 22e. ADDRESS<br>4509 Liberty Heights Rd  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/24/69   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn Balto. Md. |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Mitchell Wiedefeld Home 6500 York Rd.  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 29 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Richard J. [Signature]                 |  |

05133

RECORDS OF DEATH

RECORDS

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |                                 |  |  |   |  |  |  |
|--|---------|--|---------------------------------|--|--|---|--|--|--|
| <div>05134</div> <div>05126</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>   |         |  |                                 |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or Print)   |         |  |                                 |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR   |  |
| First Middle Last  |         |  |                                 |  |  | Month Day Year  |  | 10:20  |  |
| CHARLES EDWARD MURPHY  |         |  |                                 |  |  | MATED <input type="checkbox"/> 4 30 1969  |  | 10:20  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD Month Day Year  |  |
| Male   | White   | Jan 20 1951  | 18 YRS.                         |  |  |   |  | April 30 1969  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | 2d. HOUR   |  |
| Md   |         | USA  |                                 |  |  | Balto.  |  | 10:20  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Parkville  |         | Garage 2713 Alden Rd.  |                                 | Driver   |  | A J Auto P.   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |         | 13b. COUNTY  |                                 | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| Md.  |         | Balto.   |                                 | Parkville  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 2713 Alden Rd.   |  |
| 14. FATHER'S NAME First Middle Last  |         |  |                                 | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |  |  |
| CHARLES H. MURPHY  |         |  |                                 | CHARLOTTE CLARK  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |         |  |                                 | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| No   |         |  |                                 | 216-56-4685  |  | Family records  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                                 |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication  |         |  |                                 |  |  |   |  |  |  |
| 982X DUE TO, OR AS A CONSEQUENCE OF  |         |  |                                 |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |                                 |  |  |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |                                 |  |  |   |  |  |  |
| (c)  |         |  |                                 |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |                                 |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |                                 | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
|  |         |  |                                 | 29-4 30 1969 P.M.  |  | Unknown   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                 | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State   |  |
| Garage   |         |  |                                 | 2713 Alden Rd.   |  | Parkville   |  | Balto. Md.   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |         |  |                                 |  |  |   |  |  |  |
| ACTUAL SIGNATURE   |         |  |                                 | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                   |  | 22b. DATE SIGNED   |  |
| EXAMINER'S NAME (Type)   |         |  |                                 |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                    |  | 4/30/69  |  |
|  |         |  |                                 |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                  |  |  |  |
|  |         |  |                                 |  |  | ADDRESS (Street, city, town, or county)   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |  |
| Burial   |         | 5/3/69   |                                 | Dulaney Valley   |  | Balto 60 Md.  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |         |  |                                 | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| C.F.EVANS & SON 8802 Harford road  |         |  |                                 | MAY 1 1969   |  | Charles Judge   |  |  |  |

02130

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 05135 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |   |  |   |   |                |   |   | 05127   |                  |   |  |                   |  |
|--|--|------------------|---|--|---|---|----------------|---|---|---|------------------|---|--|-------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |   |  |   |   |                |   |   |   |                  |   |  |                   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>MARGARET   |  | Middle<br>ELIZABETH   |   | Last<br>MURPHY |   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year |   | 2b. HOUR<br>:20A |   |  |                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>May 16, 1910   |   | 6. AGE (in years<br>last birthday)<br>58 YRS.   |                | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN                   |                  | 2c. DATE PRONOUNCED DEAD<br>Month April Day 18, Year 69 |  | 2d. HOUR<br>7:20A |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |   | 9. COUNTY OF DEATH<br>Baltimore   |   |                  |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Ellicott City   |  |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>26 Westchester Avenue |   |   |                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Clerk retail store Bobs 5 & 10 cent |   |   |                  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Store           |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before<br>admission) STATE Maryland  |  |                  |   | 13b. COUNTY Baltimore  |   | 13c. CITY OR TOWN<br>Ellicott City  |                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |   | 13e. STREET AND NUMBER<br>26 Westchester Avenue |                  |   |  |                   |  |
| 14. FATHER'S NAME First Middle Last<br>Joseph Oliver Murphy  |  |                  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Lingenfelter |   |                |   |   |   |                  |   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |  |                  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>218-12-3285                         |   | 17. INFORMANT Ellicott City, ADDRESS Md. 21043<br>Miss Lucy E. Murphy 26 Westchester Avenue   |                |   |   |   |                  |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |   |  |   |   |                |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                  |   |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                  |   |  |   |   |                |   |   |   |                  |   |  |                   |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |   |   |                | 20. AUTOPSY?<br>(Partial)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   |   |                  |   |  |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                |   |   |   |                  |   |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK   |  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No.  |                | City or Town  |   | County  |                  | State   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |   |  |   |   |                |   |   |   |                  |   |  |                   |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)   |  |                  | Ronald N. Kornblum, MD.   |  |   |   |                |   | 22b. DATE SIGNED<br>4/18/69   |   |                  |   |  |                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  | 23b. DATE<br>4/21/1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John's Cemetery       |   |                | 23d. LOCATION (City or Town) (County) (State)<br>Ellicott City, Md.   |   |   |                  |   |  |                   |  |
| 24. FUNERAL DIRECTOR<br>Easton Funeral Home  |  |                  | ADDRESS<br>Catonsville, Md.   |  |   | 25a. REC'D BY REGISTRAR<br>APR 22 1969  |                |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                       |   |                  |   |  |                   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05136

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05128

|   |  |                         |  |   |  |   |  |   |  |  |  |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>GLENN</b>   |  |                         | First Middle Last<br><b>MURRAY, JR.</b>  |   |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>April 19</b>  |  |   | 2b. HOUR<br>M<br><b>M</b>  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br><b>July 4, 1924</b> |  | 6. AGE (In years last birthday)<br><b>44</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>44</b> |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>44</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2326 Lincoln Avenue</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Parts Clerk - Bethlehem Steel Co.</b>                          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 13e. STREET AND NUMBER<br><b>2326 Lincoln Avenue</b>  |  |                         | 14. FATHER'S NAME<br>First Middle Last<br><b>Glenn Murray</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Myrtle McGeary</b>  |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>390-26-8577</b>  |  |                         | 17. INFORMANT (Wife)<br><b>Mrs. Catherine R. Murray, 2326 Lincoln Ave.</b>                                 |   |  | 17. ADDRESS<br><b>Edgemere, Md.</b>   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                         |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>  |  |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| EXAMINER'S NAME (Type)  |  |                         | 22b. DATE SIGNED<br><b>4/29/69</b>   |   |  | ADDRESS (Street, city, town, or county)   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>5/2/69</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |  |                         |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 2 1969</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

08170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be excluded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 123  
45M - 1-1-69

| 05137  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 05129   |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| Item 8 Film 412 5/6/69 kk  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR  |  |  |  |  |   |  |  |  |  |
| CATHERINE W.   |  |  |  |  | NAYLOR   |  |  |  |  | 4 Month 29 69 Year   |  |  |  |  | 8:56 P M  |  |  |  |  |   |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| FEMALE   |  |  |  |  | CAUCASIAN  |  |  |  |  | 5-1-98   |  |  |  |  | 70 YRS.   |  |  |  |  |   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |   |  |  |  |  |
| Laurel Md.   |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | BALTIMORE Md.   |  |  |  |  |   |  |  |  |  |
| 1d. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |  |  |
| BALTIMORE  |  |  |  |  | GREAT. BALT. MED CENT  |  |  |  |  |  |  |  |  |  | Housewife   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  | 13e. STREET AND NUMBER                                  |  |  |  |  |
| Md.  |  |  |  |  | Balto.   |  |  |  |  | Reisterstown   |  |  |  |  |   |  |  |  |  | Westminster Road  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| Abraham  |  |  |  |  | Walter   |  |  |  |  | Elizabeth  |  |  |  |  | Strett  |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address   |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  | 213-36-1283  |  |  |  |  | Mrs. Margaret W. Licht   |  |  |  |  | Baltimore, Md.  |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>4109</u> CARDIAC ARREST   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| (b) MYOCARDIAL INFARCTION  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| (c) HEART FAILURE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>69</u> , to <u>4-29</u> , 19 <u>69</u> , that <u>X</u> (we) last saw the deceased alive on <u>4-29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4-29-69   |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| Helen C. Novak M.D.  |  |  |  |  |  |  |  |  |  | 6701 N CHARLES ST  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |   |  |  |  |  |
| Burial   |  |  |  |  | May 2, 1969  |  |  |  |  | Baltimore National   |  |  |  |  | Baltimore, Md.  |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                              |  |  |  |  |
| J.F. Eline & Sons  |  |  |  |  |  |  |  |  |  | Reisterstown, Md.  |  |  |  |  | MAY 2 1969  |  |  |  |  | Charles J. Jager  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05133<br>Item 23 Film 4/14/69 kk  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                      |  |  |  |  |  |  |  |  |  | 05130  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| GUY HENRY NAYLOR  |  |  |  |  |  |  |  |  |  | APRIL 7 1969   |  |  |  |  |  |  |  |  |  | 6:30 M   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>MALE  |  |  |  |  |  |  |  |  |  | 4. RACE<br>WHITE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>9/15/92  |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)<br>76 YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                                 |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>PENNSYLVANIA   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>BALTIMORE  |  |  |  |  |  |  |  |  |  | Md.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VETERANS ADMINISTRATION HOSPITAL |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>FARMER  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>MARYLAND   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>CARROLL   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>HAMPSTEAD   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>Rt. 2                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>HARRY --- NAYLOR   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>SUE BLACK  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>YES WW-1   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217 30 2948  |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>CLINICAL RCDS, VA HOSPITAL, FORT HOWARD MD |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>PULMONARY EMPHYSEMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>DIABETES MELLITUS</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1969   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Mar. 6</u> , 19 <u>69</u> , to <u>April 7</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>April 7</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (XXXX) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>J. D. Talbert, M.D.</u>  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>4/7/69   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>J.D. TALBERT, M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>VA Hospital, Fort Howard, Md.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>Apr. 9, 1969  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Maryland                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Joseph N. Zannino</u>  |  |  |  |  |  |  |  |  |  | ADDRESS<br>Md 21224  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>APR 8 1969  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| ZANNINO FUNERAL HOME 257 S. Conkling St. Balto  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |



1. The first part of the document is a list of names and dates, which appears to be a roster or a list of events. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

2. The second part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

3. The third part of the document is a series of handwritten notes or entries, similar to the second part. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

4. The fourth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

5. The fifth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

6. The sixth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

7. The seventh part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

8. The eighth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

9. The ninth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.

10. The tenth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates listed in the first part, possibly providing additional information or commentary.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Mildred Gertrude</i>  |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br><i>4</i> Month <i>12</i> Day Year <i>69</i>  |  |  | 2b. HOUR<br><i>7 P</i> M   |  |  |
| 3. SEX<br><i>Female</i>  |  |  | 4. RACE<br><i>White</i>   |  |  | 5. DATE OF BIRTH<br><i>July 15, 1899</i>  |  |  | 6. AGE (In years lost birthday)<br><i>69</i> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Monkton</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Hutchins Mill Road</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Homemaker</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>   |  |  | 13c. CITY OR TOWN<br><i>Monkton</i>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><i>Hutchins Mill Road</i>  |  |  | 14. FATHER'S NAME<br>First Middle Last<br><i>James Ellwood Fossett</i>                                    |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Emma Griffin Gettier</i>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>   |  |  | 17. INFORMANT<br><i>Family records</i>  |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Hypertensive arteriosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i><br><i>Years</i> |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>None</i>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>None</i>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>None</i>  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><i>None</i>               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><i>None</i>   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/4</i> , 19 <i>59</i> , to <i>4/12</i> , 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>2/19</i> , 19 <i>69</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>James F. White Jr. M.D.</i> DEGREE  |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><i>4/12/69</i>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>James F. White Jr. M.D.</i>   |  |  |   |  |  | 22e. ADDRESS<br><i>Jarrettsville, Md 21084</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, <i>Burial</i>  |  |  | 23b. DATE<br><i>April 15, 1969</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. James Cemetery</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Monkton, Maryland</i>                    |  |  |
| 24. FUNERAL DIRECTOR<br><i>John Buras' Sons, Towson, Maryland</i>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 18 1969</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |

Unlabeled (continued)

White 1000  
x 1000  
1000

Unlabeled 1000 1000 1000

Unlabeled 1000 1000 1000

Unlabeled 1000 1000 1000

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Unlabeled 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then~~ please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

|  |                              |   |  |  |   |
|--|------------------------------|---|--|--|---|
| Items 23a, 23b, 23c, 23d<br>FilmG412 5/19/69 jp  |                              | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 05132  |   |
| Item 24 FilmG412 5/8/69 kk   |                              |   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <b>05140</b> MARYLAND  |                              |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>-</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                              | c. LENGTH OF STAY IN lb<br><u>3 yrs</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Forest Haven Nursing Home</u>   |                              |   | d. STREET ADDRESS<br><u>Balto. City Hospital</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Steve</u> Middle <u>Nickoless</u> Last <u>Nickoless</u>   |                              |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>27</u> Year <u>1969</u>  |  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-28-1888</u>   | 9. AGE (In years, lost birthday)<br><u>80</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>27</u> Days <u>19</u> Hours <u>69</u> Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Yugoslavia</u>                             |   |
| 13. FATHER'S NAME<br><u>Nickoless, Joe</u>   |                              |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>unknown</u>  |                              | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Mary?</u> Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE &amp; PULMONARY EDEMA -</u><br>DUE TO <u>PNEUMONITIS</u><br>DUE TO <u>PERIPHERAL CIRCULATORY COLLAPSE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                              |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> <u>19</u> p.m.  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>66</u> , to <u>4/17</u> , 19 <u>69</u> , that (I) (we) <u>do</u> saw the deceased alive on <u>4/17</u> , 19 <u>69</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above   |                              |   |  |  |   |
| 22a. SIGNATURE<br><u>John H. Shaw M.D.</u>   |                              |   | 22b. DATE SIGNED<br><u>4/30/69</u>   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John H. Shaw M.D.</u>   |                              |   | 22d. ADDRESS<br><u>6800 E. MANHATTAN AVE., BALTO. MD.</u>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |                              | 23b. DATE THEREOF<br><u>May 1969</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Anatomy Board of Maryland</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>Hubbard Funeral Home-4107 Wilkins Ave. Balto. Md.</u>   |                              |   | 25a. REC'D BY REGISTRAR<br>DATE <u>MAY 5 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John H. Shaw</u>   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05141

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05133

|   |                         |  |  |  |                               |   |  |
|---|-------------------------|--|--|--|-------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>ANN M. Nickolson</b>  |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br><b>APR 16 1969</b> |  |                               | 2b. HOUR <b>4:45</b> M.   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Nov. 4, 1899</b>  | 6. AGE (in years last birthday)<br><b>69</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>APR 16 1969</b>                                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                               | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address)<br><b>WARDS Chapel Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>   |                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 14. FATHER'S NAME First Middle Last<br><b>Toshua L. Green</b>   |                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY - Herbert</b>                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)<br><b>No</b>  |                               | 16b. SOCIAL SECURITY NO.<br><b>—</b>  |  |
| 17. INFORMANT<br><b>Mrs. Harold Grimes</b>  |                         | ADDRESS<br><b>Owings Mills, Md.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive C.V. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b> |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>18 yrs.</b><br><b>18 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                         |  |  |  |                               |   |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |                               | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH <b>none</b>   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                               |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                               |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |  |                               |   |  |
| ACTUAL SIGNATURE<br><b>D. D. Caples</b>   |                         | M.D.<br><b>D. D. CAPLES, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                               | 22b. DATE SIGNED<br><b>4-18-69</b>  |  |
| EXAMINER'S NAME (Type)<br><b>D. D. CAPLES, M.D.</b>   |                         | ADDRESS<br><b>6 Hammond St., Randallstown, Md.</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                               | 23b. DATE<br><b>4-19-69</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>   |                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown, Md.</b>                          |  | 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>   |                               | ADDRESS<br><b>Lykesville, Md.</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>APR 22 1969</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>W. L. ...</b>   |  |  |                               |   |  |

0514

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

|                         |  |                         |  |
|-------------------------|--|-------------------------|--|
| TO :                    |  | FROM :                  |  |
| SUBJECT :               |  | RE :                    |  |
| DATE :                  |  | TIME :                  |  |
| BY :                    |  | APPROVED :              |  |
| SPECIAL AGENT IN CHARGE |  | SPECIAL AGENT IN CHARGE |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05142

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05134

|   |  |  |                |   |   |   |   |   |  |
|---|--|--|----------------|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Anna  | Middle<br>Emma | Last<br>Norwitz   | 2a. DATE OF DEATH<br>April Month 12 Day 1989 Year                               |   | 2b. HOUR<br>5:55p.M   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |                | 5. DATE OF BIRTH  |   | 6. AGE (In years<br>last birthday)<br>73 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore County Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Co. Gen. Hosp. |                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>AT HOME   |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore   |                | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>7018 Park Hgts. Ave.  |  |
| 14. FATHER'S NAME<br>Morris   |  | First<br>Middle<br>Last<br>Satsky  |                | 15. MOTHER'S MAIDEN NAME<br>Miriam  |   | First<br>Middle<br>Last<br>XXXXXX   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>BT  |  | (If yes give war or dates of service)  |                | 16b. SOCIAL SECURITY NO.<br>215-32-9184   |   | 17. INFORMANT<br>MR. GERSON NORWITZ, 2024 COLEBROOK DR.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute MI</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>A few</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>69</u> , to <u>4-12</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>4-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) did (did not) view the body after death.    |  |  |                |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>G. Nearfon</u>   |  | 22c. PHYSICIAN'S<br>NAME (Type)<br>G. NEARFON  |                |   | 22d. ADDRESS<br>BALTO. CO. GEN. HOSP.   |   | 22e. DATE SIGNED<br>4-12-69   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>4-14-69   |                | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAI ISRAEL   |   | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |   |   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |                | 25a. REALTOR REGISTRAR<br>DATE<br>APR 15 1969   |   | 25b. REGISTERED<br>JUDGE  |   |   |  |

WASHINGTON, D.C.

APR 12 1909

1-14-09

FOR THE SECRETARY OF AGRICULTURE

1621  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |        |   |   |   |   |   |      |
|--|--|---|--------|---|---|---|---|---|------|
| 05143  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |        |   |   | 05135   |   |   |      |
| 1. DECEASED-NAME<br>(Type or print)  |  |   |        | First   | Middle  | Last  | 2a. DATE OF DEATH   | 2b. HOUR  |      |
| FRANCIS  |  |   |        | J   |   | NOWLAND   | 4 Month 28 Day 69 Year  | 4P M  |      |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH  |   | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |      |
| MALE   |  | CAUCASIAN   |        | 10-14-24  |   | 44 YRS.   |   |   |      |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |   |      |
| Md.  |  | U.S.A.  |        |   |   | BALTIMORE Md.   |   |   |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |      |
| BALTIMORE, MD  |  | GREAT. BALT. MED. CENT  |        | truck driver  |   | Balt. City  |   |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                          |      |
| Md.  |  | 136. COUNTY   |        | Baltimore   |   |   |   | 1207 W. Cross St.                               |      |
| 14. FATHER'S NAME  |  | First   | Middle | Last  | 15. MOTHER'S MAIDEN NAME  |   | First   | Middle  | Last |
| William J.   |  |   |        | Nowland   | Clara Nelson  |   |   |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |   | Address   |   |   |      |
| Yes, no, or (unknown)  |  |   |        | Mrs Clara Nowland   |   | above   |   |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CA OF LUNG WITH METASTASIS</u><br><u>1621</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____     |  |   |        |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |        |   |   |   |   |   |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> , 19 <u>69</u> , to <u>4-28</u> , 19 <u>69</u> , that <u>no</u> (we) last<br>saw the deceased alive on <u>4-28</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <u>(I/we)</u> (did) (did not) view the body after death. |  |   |        |   |   |   |   |   |      |
| 22b. SIGNATURE<br><u>BIK Choi M.D.</u> DEGREE  |  |   |        |   | ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>42-8-69</u>                                      |   |      |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>BIK CHOI, M.D.</u>   |  |   |        |   | 22e. ADDRESS<br><u>6701 N CHARLES, ST.</u>  |   |   |   |      |
| 23a. BURIAL, CREMATION<br>REMOVAL (Specify)  |  | 23b. DATE<br><u>5/1/69</u>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cem.</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Woodlawn Md.</u>                            |   |   |      |
| 24. FUNERAL DIRECTOR<br><u>John C. ...</u>   |  | ADDRESS<br><u>Baltimore</u>   |        | 25a. REC'D BY REGISTRAR<br>DATE<br><u>APR 30 1969</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>...</u>  |   |   |      |

05123

OFFICE OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |                         |  |
|---|--|--|--|--|--|---|--|-----------------------------------|-------------------------|--|
| <div>05144</div> <div>CERTIFICATE OF DEATH</div> <div>05136</div>   |  |  |  |  |  |   |  |                                   |                         |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |                         |  |
| ROSE ELLEN O'DONNELL  |  |  |  |  |  | 4 Month 14 Day 69 Year  |  | 7:40 AM                           |                         |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |                         |  |
| FEMALE  |  | WHITE  |  | 12-11-1881   |  | 87 YRS.   |  | MONTHS DAYS HOURS MIN             |                         |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |                         |  |
| ALLENTOWN, PA   |  | USA  |  |  |  | MICHIGAN Baltimore Md.  |  |                                   |                         |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                         |  |
| TOWSON  |  |  | DULANEY TOWSON NURSING HOME - WEST ROAD                                      |  |  | Homemaker   |  |                                   |                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER  |  |
| MD.   |  |  | BALTO.   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 2121 402 OVERBROOK ROAD |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |                         |  |
| DENNIS DUGEN GILLISPIE, ANNIE DUGEN   |  |  |  |  |  |   |  |                                   |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |                         |  |
| No  |  |  | 162 03 5767  |  | Thomas J. O'Donnell Stevenson, Md  |   |  |                                   |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   |                         |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                                   |                         |  |
| IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u>   |  |  |  |  |  |   |  |                                   |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Breast</u>  |  |  |  |  |  |   |  |                                   |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |                                   |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                   |                         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |                         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1968</u> , to <u>April 11, 1969</u> , that (I) (we) saw the deceased alive on <u>4/11</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |                         |  |
| 22b. SIGNATURE <u>Laurence C. Post M.D.</u> DEGREE  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>4/15/69</u>  |                                   |                         |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Laurence C. Post</u>  |  |  |  |  | 22e. ADDRESS <u>6805 York Rd.</u>  |   |  |                                   |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |                         |  |
| Burial  |  | 4/16/69  |  | Cathedral Cemetery   |  | Baltimore Balto Md  |  |                                   |                         |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE   |   | 25b. REGISTRAR'S SIGNATURE   |                                   |                         |  |
| Mitchell Wiedefeld Home 6500 York Rd.   |  |  |  |  | APR 18 1969  |   | <u>Charles Judge</u>   |                                   |                         |  |

55120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M - 1968

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                                   |                        |  |
|---|--|--|--|--|--|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |                        |  |
| 05145   |  |  |  |  |  |   |  |                                   |                        |  |
| 05137   |  |  |  |  |  |   |  |                                   |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |                        |  |
| David A O'Donoghue  |  |  |  |  |  | 4 Month 25 Day 69 Year  |  | 12 M                              |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |                        |  |
| Male  |  | White  |  | 10-24-99   |  | 69 YRS.   |  | MONTHS DAYS HOURS MIN             |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |                        |  |
| Baltimore   |  | U.S.   |  |  |  | Baltimore County Md.  |  |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| Randallstown  |  |  | Baltimore Gen. Hospital  |  |  | Carpenter   |  |                                   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Balto  |  | Baltimore  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 7407 Digby Rd.         |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |                                   |                        |  |
| First Middle Last   |  |  | First Middle Last  |  |  |   |  |                                   |                        |  |
| C. C. O'Donoghue  |  |  | Catherine Warthen  |  |  |   |  |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |                        |  |
| WW1   |  |  | 214-06-0553  |  | Dorothy M. O'Donoghue - 7407 Digby Rd. #7  |   |  |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   |                        |  |
| PART I. DEATH CAUSED BY:  |  |  |  |  |  |   |  |                                   |                        |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>  |  |  |  |  |  |   |  |                                   |                        |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                   |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u>   |  |  |  |  |  |   |  |                                   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |                                   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                   |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-25, 1969, to 4-25, 1969, that (I) (we) lost the deceased on 4-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |                        |  |
| 22b. SIGNATURE <u>Jonathan Papano</u>   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 4-25-69   |                                   |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS   |   |  |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |                        |  |
| Burial  |  | 4-29-69  |  | Lorraine Cemetery  |  | Baltimore, Maryland   |  |                                   |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |                        |  |
| Armacost Funeral Chapel-4600 Liberty Hts  |  |  |  |  | DATE APR 28 1969   |   | <u>Charles Judge</u>   |                                   |                        |  |

05153

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| 05146  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| 05138  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | First<br>Martin   |  | Middle<br>S.   |  | Last<br>Olson Jr.   |  | 2a. DATE OF DEATH<br>Month Day Year<br>4 25 1969                            |  | 2b. HOUR<br>M                  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cau.  |  | 5. DATE OF BIRTH<br>11-26-1917  |  |  |  | 6. AGE (In years<br>last birthday)<br>51 YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore  |  |   |  | Md.   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Parkville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>8100 Harford Road |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Machine operator |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Armco Co.                       |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Parkville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  | 13e. STREET AND NUMBER<br>8569 Water Oak Road 21234                     |  |   |  |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Samuel M. Olson  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Sarah League   |  |  |  |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br>Yes No or unknown<br>Yes W.W.II   |  | 16b. SOCIAL SECURITY NO.<br>213-03-9318  |  | 17. INFORMANT<br>Mrs Dorothy Olson 8569 Water Oak Road 21234  |  |  |  |   |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Barroymal Metabolic Toxication</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Anticoagulant heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Stage 4 Hypertension</u>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 min.<br>2 yr.<br>1 yr. |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1966, to April 1969, that (I) (we) last saw the deceased alive on 4/25/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |                                |  |
| 22b. SIGNATURE<br><u>S. Elliott Harris</u>   |  |  |  | 22c. DATE SIGNED<br>4/26/69   |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>S. Elliott Harris   |  | 22e. ADDRESS<br>8100 Harford Road 21234                                 |  |   |  |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>4-28-1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Park   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co. Md.   |  |   |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7601 Belair Road 21236  |  |  |  | 25a. REC'D BY REGISTRAR<br>APR 29 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Michael J. Under   |  |   |  |   |  |                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |                                    |  |  |   |  |
|---|--|---|------------------------------------|--|--|---|--|
| 05147   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                                    |  |  | 05139   |  |
| CERTIFICATE OF DEATH  |  |   |                                    |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Bertha Louise Ortman  |  |   | 2a. DATE OF DEATH<br>April 27 1969 |  |  | 2b. HOUR<br>11:50 A. M.   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |                                    | 5. DATE OF BIRTH<br>July 28 1880   |  | 6. AGE (In years last birthday)<br>88 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Katharine Robb Nursing Home - 4105 Essex Rd. |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |                                    | 13c. CITY OR TOWN<br>B   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br>William Baltz  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Gehb XXXXX   |                                    | 13e. STREET AND NUMBER<br>4105 Essex Rd. 21207   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-30 8160   |                                    | 17. INFORMANT<br>Mrs. Bertha L. Crase 3405 Kimble Rd. Baltimore 21207  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>age</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>  |  |   |                                    |  |  |   |  |
| 19a. DATE OF OPERATION<br>4/21/69   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fx (R) Leg  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21b. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 4:18 1969   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Lying in bed -  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br>Nursing Home (Katharine Robb)                 |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>4105 Essex Road Baltimore  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2, 1965, to 4/27, 1968, that (I) (we) last saw the deceased alive on 4/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                                    |  |  |   |  |
| 22b. SIGNATURE<br>Elliot Menkowitz  |  | DEGREE<br>M.D.  |                                    | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>4/27/69   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Elliot Menkowitz  |  | 22e. ADDRESS<br>212 ENCHANTED HILLS Rd. Catonsville, Md.  |                                    |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-30-69  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>Armocost Funeral Chapel-4600 Liberty Hts.   |  | ADDRESS   |                                    | 25a. REC'D BY REGISTRAR<br>APR 30 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>W. C. ...   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 1 & 2 Film 411  
4/14/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
05148

CERTIFICATE OF DEATH

05140

|   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Temple Mae Osburn</b>   |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>4 3 69</b>  |  |  | 2b. HOUR<br><b>1:30 A.M.</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Cau</b>   |  |  | 5. DATE OF BIRTH<br><b>3/30/75</b>  |  |  | 6. AGE (In years last birthday)<br><b>94</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Tenn</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>126 Woodlawn Ave</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Florida</b> MD   |  |  | 13b. COUNTY <b>Balt</b>   |  |  | 13c. CITY OR TOWN <b>Woodlawn</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER <b>111 Northeast</b>   |  |  | 13f. <b>7777/99/11</b>  |  |  | 13g. <b>26th</b>  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Weaver</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Virginia Edwards</b>                                   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT<br><b>Anna Lee Muhn</b>   |  |  | 18. ADDRESS<br><b>138 NE 26th St Miami, Fla</b>   |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Decompenation</b><br><b>4409</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo.</b><br><b>20 yrs.</b>               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-28</b> , 1961, to <b>4-3-</b> , 1969, that (I) (we) lost the deceased alive on <b>4-1-</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Wilmer K. Gallagher Sr M.D.</b> DEGREE   |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>4/3/69</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher Sr M.D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>6209 Frederick Ave Balt Md 21228</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>4/7/69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Miami City Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Miami Florida</b>                        |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson Inc Balt. Md. 21204</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 7 1969</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

125148

RECEIVED 11 MAR 1968

U.S. AIR FORCE

11 MAR 1968

TO: DIRECTOR, AIR FORCE RESEARCH AND DEVELOPMENT COMMAND

FROM: SAC, AIR FORCE RESEARCH AND DEVELOPMENT COMMAND

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |   |  |  |   |  |
|---|--|--|--------------------------|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |  |  |   |  |
| 05149   |  |  |                          |  |   |  |  |   |  |
| 05141   |  |  |                          |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| JESSIE  |  |  | E                        |  |   | PAINTER  |  | 4 Month 4 Day 69 Year 6:45 PM                           |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| FEMALE  |  | CAUCASIAN  |                          | 4-26-1890  |   | 78 YRS.  |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |  |
| New York  |  | USA  |                          |  |   | BALTIMORE  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| BALTIMORE   |  | GREAT. BALT. MED. CENT.  |                          |  |   | Housewife  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                                  |  |
| Md.   |  | Baltimore  |                          | Baltimore  |   |  |  | 7208 Park Drive   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |  |   |  |
| First Middle Last   |  |  | First Middle Last        |  |   |  |  |   |  |
| James   |  |  | Fraser                   |  |   | Unknown  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT Address   |  |  |   |  |
| No  |  |  |                          |  | Mr. Robert L. Painter, 7414 Phila. Rd. 21237                                      |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |   |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |  |   |  |  |   |  |
| IMMEDIATE CAUSE (a) CERE BRO VASCULAR ACCIDENT  |  |  |                          |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |   |  |  |   |  |
| (b) ESSENTIAL HYPERTENSION  |  |  |                          |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |   |  |  |   |  |
| (c)   |  |  |                          |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                          |  |   |  |  |   |  |
|   |  |  |                          |  |   |  |  |   |  |
| MEDICAL CERTIFICATION   |  |  |                          |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-26, 19 69, to 4-4, 19 69, that (X) (we) last saw the deceased alive on 4-4, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |   |  |  |   |  |
| 22b. SIGNATURE  |  |  |                          |  | 22c. DATE SIGNED  |  |  |   |  |
| DR. GEORGE PIKLER   |  |  |                          |  | 4-4-69  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |  | 22e. ADDRESS  |  |  |   |  |
| DR. GEORGE PIKLER   |  |  |                          |  | 6701 N CHARLES ST BALT, MD  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |
| Burial  |  | 4/8/69.  |                          | Baltimore National Cemetery  |   | Baltimore, Md.   |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |                          |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |
| K J RUCIC INC 5305 HARFORD RD.  |  |  |                          |  | APR 7 1969  |  | Charles Judge  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><i>Irvin</i>   |  |  | Middle<br><i>Clyde</i>  |  |  | Last<br><i>Palmer</i>   |  |  |
| 2a. DATE OF DEATH  |  |  | Month <i>20</i> , Day <i>69</i> Year  |  |  | 2b. HOUR  |  |  | 2;15 <sup>P</sup> M.  |  |  |
| 3. SEX<br><i>Male</i>  |  |  | 4. RACE<br><i>White</i>   |  |  | 5. DATE OF BIRTH<br><i>August 4, 1895</i>   |  |  | 6. AGE (In years last birthday)<br><i>73</i> YRS.                                 |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto. Co.</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>13 Butler Road</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Superintendent</i>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  |  | 13b. COUNTY<br><i>Balto.</i>  |  |  | 13c. CITY OR TOWN<br><i>Reisterstown</i>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><i>13 Butler Road</i>  |  |  | 14. FATHER'S NAME<br>First <i>Hiram</i> Middle <i>V.</i> Last <i>Palmer</i>                           |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Lydia</i> Middle <i>E.</i> Last <i>Shaffer</i>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)<br><i>Yes</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>212-10-8061</i>  |  |  | 17. INFORMANT<br><i>Mrs. Bessie E. Palmer</i>   |  |  | Address<br><i>Reisterstown</i>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Arteriosclerotic C.V. Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 mins.</i><br><br><i>years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 22, 1969</i> , to <i>Apr. 20, 1969</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>Apr. 1, 1969</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.       |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Martin E. Strobel, M.D.</i>   |  |  |   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><i>4-21-69</i>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Martin E. Strobel, M.D.</i>   |  |  |   |  |  | 22e. ADDRESS<br><i>59 Hanover Rd. Reisterstown, Md.</i>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>April 23, 69</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>All Saints Cemetery</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Reisterstown, Md.</i>         |  |  |
| 24. FUNERAL DIRECTOR<br><i>J. F. Cline &amp; Sons</i>  |  |  |   |  |  | ADDRESS<br><i>Reisterstown, Md.</i>   |  |  | 25a. REC'D BY REGISTRAR<br><i>APR 23 1969</i>                                     |  |  |
|  |  |  |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard J. Judge</i>                             |  |  |

05120

TEMPERATURE OF DEATH

10-2-2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05151   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 05143   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>WILLIAM JOSEPH PARSONS</b>  |  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>1</b> Year <b>1969</b>   |  |  |  | 2b. HOUR <b>4 P M</b>                             |  |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>7-18-03</b>   |  | 6. AGE (In years lost birthday) <b>65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore County, Md.</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>MT WILSON</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>629 E. 36th Street</b>  |  |  |  |
| 14. FATHER'S NAME First <b>GUY</b> Middle <b>PARSONS</b> Last <b>STELLA</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>GALLAGHER</b> Middle <b>GALLAGHER</b> Last <b>GALLAGHER</b>            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>Korea</b>                             |  |  |  | 16b. SOCIAL SECURITY NO. <b>215-03-0686</b>       |  |  |  |
| 17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>   |  |  |  | Address <b>Records, Mt. Wilson State Hospital</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE COR pulmonale</b><br><b>011.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RESPIRATORY FAILURE (ASPIRATION pneumonia)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC OBSTRUCTIVE AIRWAY DISEASES</b> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)<br><b>Suspect pulmonary tuberculosis</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>69</b> , to <b>4/1</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/1</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>W Newcomer</b>  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE-SIGNED <b>4/1/1969</b>   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>  |  |  |  | 22e. ADDRESS <b>Mount Wilson, Maryland</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>4/4/1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>                           |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>   |  |  |  | ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>APR 2 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b> |  |  |  |

Division of

United States Department of the Interior

Geological Survey, Washington, D.C.

William H. Woodworth, M.D., Mount Wilson, California

Dr. J. H. Woodworth, Mount Wilson, California

Dr. J. H. Woodworth, Mount Wilson, California

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05152

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05144

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES ROBERT PAYNE</b>  |  |   | 2a. DATE OF DEATH<br><b>APRIL</b> Month <b>7</b> Day <b>1969</b> |   |  | 2b. HOUR<br><b>8:45</b> <sup>P</sup>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>July 3, 1917</b>   |  | 6. AGE (In years last birthday)<br><b>51</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GR. BALTO. MED. CENTER</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Roofing Mechanic-Hopkins</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>4003 Chesterfield Ave.</b>  |  | 14. FATHER'S NAME<br>First <b>Charles W.</b> Middle <b>Payne</b> Last   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mamie</b> Middle <b>Engelmann</b> Last   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>yes Navy, WW 2</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>2 219-01-4271</b>  |  | 17. INFORMANT<br>Address<br><b>Rita Schraudner Payne, wife, above</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COMA</b><br><b>1990</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>MULTIPLE CARCINOMABOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 MONTHS</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/13/1969</b> , to <b>4/7/1969</b> , that (I) (we) last saw the deceased alive on <b>4/7/1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Neeraja Thakur</b>  |  | DEGREE<br><b>DR. NEERAJA THAKUR</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4/7/69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. NEERAJA THAKUR</b>  |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/10/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>APR 11 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

00150

EXHIBIT 10

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1 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |   |  |  |   |  |
|---|--|--|--------------------------|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| WILLIAM MARION PEARSON  |  |  |                          |  |   | April Month 1 Day 1969 Year  |  | 7:50 M  |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| Male  |  | White  |                          | 6/22/08  |   | 80 YRS.  |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |  |
| MARYLAND  |  | U.S.A.   |                          |  |   | BALTIMORE  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| FORT HOWARD   |  | VETERANS ADMINISTRATION HOSPITAL   |                          | MAIL ROOM CLERK  |   | NEWS PAPERS  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                  |  |
| MARYLAND  |  |  |                          | BALTIMORE  |   |  |  | 823 EUTAW STREET  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |  |   |  |
| First Middle Last   |  |  | First Middle Last        |  |   |  |  |   |  |
| WILLIAM PEARSON   |  |  | GRACE BITTLE             |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT  |   | Address  |  |   |  |
| YES   |  | WW-11  |                          | 212 03 1436  |   | Clinical Rcds VA Hospital, Fort Howard, Md.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |  |   |  |  |   |  |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION   |  |  |                          |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |   |  |  |   |  |
| ARTERIOSCLEROTIC HEART DISEASE  |  |  |                          |  |   |  |  |   |  |
| (b) <del>CHRONIC BRONCHITIS</del>   |  |  |                          |  |   |  |  |   |  |
| (c) PULMONARY EMPHYSEMA   |  |  |                          |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                          |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)   |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Mar 17, 19 69, to April 1, 19 69, that (X) (we) lost the deceased alive on April 1, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. |  |  |                          |  |   |  |  |   |  |
| 22b. SIGNATURE J. D. Talbert, M.D.  |  |  |                          |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 4/1/69  |   |  |
| 22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.  |  |  |                          |  | 22e. ADDRESS VA Hospital, Fort Howard, Md.  |  |  |   |  |
| 23a. BURIAL, CREMATION, (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |
| Burial  |  | 4-4-69   |                          | Baltimore Cemetery   |   | Baltimore, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS RUCK FUNERAL HOME 5305 Harford Rd Balto, Md.   |  |  |                          |  | 25a. REC'D BY REGISTRAR DATE APR 3 1969   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |

05132

CENTRAL DEPT. OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|---|--|
| 05155  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05147   |  |
| Item 10 Film 411 4/15/69 kk  |  | CERTIFICATE OF DEATH   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle   |  | Last  |  |
| Mary L. Peddicord  |  |  |  |  |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  |
| Female   |  | Cauc.  |  | 1/16/1885  |  | 84 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |
| Md.  |  | U.S.A.   |  |  |  | Balto.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  |  | 2507 Harwood Rd.   |  | Retired  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 2507 Harwood Rd.   |  | Balto.   |  |  |  | 2507 Harwood Rd.  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   |  | Last  |  |
|  |  |  |  |  |  |   |  |
| 15. MOTHER'S MAIDEN NAME   |  | First  |  | Middle   |  | Last  |  |
|  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address   |  |
| No   |  | 220-05-8537  |  | Gerald Peddicord   |  | 3441 Roland Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
| 4109   |  | Acute myocardial infarction 48 hr.   |  | Arteriosclerotic Cardiovascular disease  |  | Generalized atherosclerosis   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/15/69, and that (my) (our) opinion on death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED  |  |
| FRANK T. KASIK   |  |  |  |  |  | 4/15/69   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |   |  |
|  |  | 7005 HARFORD RD  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |
| Burial   |  | 4/7/69   |  | Poplar Grove   |  | Warren Balto. Co. Md.   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Paul E. Chenoweth  |  | 3617 Chestnut Ave  |  | APR 10 1969  |  | Charles Judge   |  |

1917-18-19

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|--|--|------------------------------|--|--|--|
| 05156  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05148  |  |                              |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH            |  | 2b. HOUR                                     |  |
| GIOVANNA   |  |  |  | PELLEGRINI   |  |  |  | APRIL Month 7, Day 1969 Year |  | 1:05A  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS.                             |  |
| FEMALE   |  | WHITE  |  | JANUARY 18, 1888   |  | 81 YRS.  |  | MONTHS DAYS                  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                              |  | Md.  |  |
| Italy  |  | USA  |  |  |  | BALTIMORE,   |  |                              |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                              |  |  |  |
| TOWSON   |  | ST. JOSEPH HOSPITAL  |  | HOMEMAKER  |  |  |  |                              |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER       |  |  |  |
| MARYLAND   |  |  |  | BALTIMORE  |  |  |  | 4206 BERGER AVE. #21206      |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME     |  | First Middle Last                            |  |
| THOMAS   |  |  |  | Di BONA.   |  |  |  | ANTONIA                      |  | SALUVCCI                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address                      |  |  |  |
| NO   |  |  |  | 217-09-2840  |  | NICHOLAS PELLEGRINI  |  | 4206 BERGER AVE.             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE AND PNEUMONIA<br>4124<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |                              |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                              |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                              |  |  |  |
|  |  |  |  |  |  |  |  |                              |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from March 23, 1969, to April 7, 1969, that (X) (we) lost the deceased alive on April 7, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                              |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |                              |  |  |  |
| Beatriz P. Dizon   |  |  |  |  |  | April 7, 1969  |  |                              |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |  |  |                              |  |  |  |
| Beatriz P. Dizon, M.D.   |  | 7620 York Road Towson, Md. #21204  |  |  |  |  |  |                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                              |  |  |  |
| BURIAL   |  | APR 10 1969  |  | HOLY REDEEMER CEMETERY   |  | 4430 BELAIR RD BALTO MD  |  |                              |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                              |  |  |  |
| DIPPEL BROS INC  |  | 7110 BELAIR ROAD   |  | APR 9 1969   |  | Charles J. [Signature]   |  |                              |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |   |  |  |  |
| 05157   |  |   |   |   |   |   |  |  |  |
| 05149   |  |   |   |   |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |   |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>ROY ELDON PERRY</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>22nd</b> Year <b>1969</b>              |   |   | 2b. HOUR<br><b>10:00 AM</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>SEPTEMBER 12 1889</b>  |   | 6. AGE (In years last birthday)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>FERRISBURG VT</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Phoenix</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Paper Mill Road</b>                                    |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>Phoenix</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>PAPER MILL ROAD</b> |  |
| 14. FATHER'S NAME<br>First <b>ALBERT</b> Middle <b>PERRY</b> Last <b>PERRY</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>SOPHARONIA</b> Middle <b>-</b> Last <b>COYER</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown <b>NO</b> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-7867</b>  |   | 17. INFORMANT<br>Address<br><b>MRS. LEAH S. PERRY (wife) Phoenix, Md</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis complicated</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 18th</b> , 19 <b>69</b> , to <b>April 22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>April 22nd</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Henry M. Conkle</b>  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-23-69</b>  |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Henry M. Conkle MD</b>   |  | 22e. ADDRESS<br><b>Phoenix, Maryland (21131)</b>  |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-25-1969</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wm. Cook-B ooks Towson 1050 York Road 21204</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>APR 24 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 yrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |   |                                   |                              |  |      |
|---|--|--|--|---|---|--|---|-----------------------------------|------------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |   |                                   |                              |  |      |
| 05158   |  |  |  |   | 05150   |  |   |                                   |                              |  |      |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |                                   |                              |  |      |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH  |   |                                   | 2b. HOUR                     |  |      |
| WINIFRED  |  |  | A.   |   | PETERSEN  | Month 4 Day 22 Year 1969   |   |                                   | 8:00aM                       |  |      |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS    |                              |  |      |
| Female  |  | Caucasian  |  | 12/10/26  |   | 42 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN.    |                              |  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |                                   |                              |  |      |
| Baltimore   |  | USA  |  |   |   | Baltimore Md.  |   |                                   |                              |  |      |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                              |  |      |
| Towson, Md.   |  |  | Greater Balto. Med. Center   |   |   | Clerical   |   | Jordan Dry Cleani                 |                              |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                   | 13e. STREET AND NUMBER       |  |      |
| Md.   |  |  | Baltimore  |   | Balto.  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 21220 ng<br>50 Dogwood Drive |  |      |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |   |                                   | First                        | Middle                                       | Last |
| Sylvester Deverell  |  |  |  |   |   | Jane Donahur   |   |                                   |                              |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT Address  |   |                                   |                              |  |      |
| (If yes give war or dates of service)   |  |  | 216-20-5470  |   |   | Randolph A. Petersen, son, above   |   |                                   |                              |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |  |   |                                   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |  |   |                                   |                              |  |      |
| IMMEDIATE CAUSE (a) Cerebral edema and subarachnoid hemorrhage  |  |  |  |   |   |  |   |                                   |                              |  |      |
| 2530 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |  |   |                                   |                              |  |      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |  |   |                                   |                              |  |      |
| (b) Hypophysectomy  |  |  |  |   |   |  |   |                                   |                              |  |      |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |  |   |                                   |                              |  |      |
| (c)   |  |  |  |   |   |  |   |                                   |                              |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |                                   |                              |  |      |
| MEDICAL CERTIFICATION   |  |  |  |   |   |  |   |                                   |                              |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |                              |  |      |
| 4/18/69   |  | Acromegaly   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | YES   |                                   |                              |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |                                   |                              |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |   |                                   |                              |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1969, to 4/22, 1969, that (I) (we) last saw the deceased alive on 4/22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |                                   |                              |  |      |
| 22b. SIGNATURE  |  |  |  |   | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED             |  |      |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | Rudiger Breitenecker, M. D.   |  | 22e. ADDRESS  |                                   | 4/22/69                      |  |      |
| Greater Baltimore Medical Center  |  |  |  |   |   |  |   |                                   |                              |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION (City or Town) (County) (State)   |                                   |                              |  |      |
| Burial  |  | 4/25/69  |  | Barkwood Cemetery   |   |  | Baltimore, Md.  |                                   |                              |  |      |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |                                   |                              |  |      |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane  |  |  |  |   | APR 25 1969   |  | Charles Judge   |                                   |                              |  |      |

08158

STATE OF TEXAS

COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05159

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05151

CERTIFICATE OF DEATH

|  |                     |   |   |   |  |
|--|---------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Hazel Mae Phillips</b>   |                     |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 2 1969</b>  |   | 2b. HOUR<br>MIN.<br><b>11 14 PM</b>                |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>1-22-07</b>  |   | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b>                               |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Bus</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md</b>   |                     | 13b. COUNTY<br><b>Pr Geo</b>  | 13c. CITY OR TOWN<br><b>Camp Springs</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET AND NUMBER<br><b>6614 Veltre Drive</b> |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Britton</b>  |                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Linda Yarger</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>209-32-1378</b>  |   | 17. INFORMANT Address<br><b>Records, Mt. Wilson, State Hospital</b>                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b><br><b>519.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Obstructive Airway Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Melitus Cerebrovascular Accident</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>2 years</b> |                     |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(d)   |                     |   |   |   |  |
| 19a. DATE OF OPERATION   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> , 19 <b>69</b> , to <b>4-2</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-2-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                     |   |   |   |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |                     | DEGREE ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-2-69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |                     | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 23b. DATE<br><b>Apr. 5, 1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sanborn Cemetery</b>   |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Clearfield Co. Penna.</b>  |                     | 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons Reisterstown, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  |
|  |                     |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
|---|--|---|--|--|--|---|---|--|-----------------------------------|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| 05160   |  | 05152   |  |  |  |   |   |  |                                   |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>First Minnie Middle Madelina Last Piel</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>12</b> Year <b>69</b>  |   |  | 2b. HOUR<br><b>9.45A</b>          |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br><b>2-27-87</b>   |  |   | 6. AGE (In years last birthday)<br><b>82</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS<br>OAYS |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>Balto.</b>               |  |                                   | Md.  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore County Gen</b>  |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Clerk- Real Estate Office</b> |                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Balt Md.</b>  |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Phoenix</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                   | 13e. STREET AND NUMBER<br><b>Bx 310 Merrymans Mill Rd.</b> |                                   |  |
| 14. FATHER'S NAME<br><b>First Lamottee Middle Hamilton Last Martyne</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>First Mary Middle McCoy Last</b>  |  |   |   |  |                                   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-28-7700</b>   |  | 17. INFORMANT<br><b>Baltimore County General Hospital</b>   |   |  |                                   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| IMMEDIATE CAUSE (a) <b>188X Congestive heart failure</b>  |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized carcinomatosis; urinary</b>   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>bladder carcinoma</b>   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| MEDICAL CERTIFICATION   |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |                                   |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |   |   |  |                                   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-2-69</b> , to <b>4-12-69</b> , that (I) (we) last saw the deceased alive on <b>4-12-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |  |                                   |  |                                   |  |
| 22b. SIGNATURE<br><b>DR Barton</b>  |  |   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-12-69</b>   |                                   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  |  |  | 22e. ADDRESS  |   |  |                                   |  |                                   |  |
| 23a. BURIAL, CREMATION, ETC.<br>(Specify)   |  | 23b. DATE<br><b>Apr. 15, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>   |  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Maryland</b>   |                                   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road</b>   |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 15 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                   |  |                                   |  |

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75-2-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |   |  |
|--|--|--|---|--|--|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |   |  |
| 05161  |  |  |   |  |  |   |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>FANNIE   |  |  | Middle<br>POMERANTZ   |  |  | Lost  |   |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>MAY 21, 1892  |  |  | 20. DATE OF DEATH<br>April Month 13 Day 1969  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>POLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 6. AGE (In years lost birthday)<br>76 YRS.  |   |  |
| 7c. IF UNDER 1 YEAR<br>MONTHS  |  |  | 7d. IF UNDER 24 HRS.<br>DAYS  |  |  | 7e. IF UNDER 24 HRS.<br>HOURS   |  |  | 7f. IF UNDER 24 HRS.<br>MIN.  |   |  |
| 7g. COUNTY OF DEATH<br>BALTIMORE   |  |  | Md.   |  |  |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br># 7618 LABYRINTH ROAD |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET AND NUMBER<br>7618 LABYRINTH ROAD  |  |  |   |  |  |   |  |  |   |   |  |
| 14. FATHER'S NAME<br>ABRAHAM   |  |  | First<br>Middle<br>Last<br>LEVIN  |  |  | 15. MOTHER'S MAIDEN NAME<br>FRIEDA  |  |  | First<br>Middle<br>Last<br>BRUCE  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>405-82-2615   |  |  | 17. INFORMANT<br>MRS. FRIEDA TATELBAUM  |  |  | Address<br>6104 Benhurst Road   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>4109 |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>1 year |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>   |  |  |   |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 28</u> , 19 <u>68</u> , to <u>April 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br>Manuel Levin M.D.  |  |  |   |  |  | 22c. DATE SIGNED<br>4/13/69   |  |  |   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>MANUEL LEVIN, M.D.   |  |  |   |  |  | 22e. ADDRESS<br>6101 PARK HOTS AVE, BALTO-15 MD.  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |  | 23b. DATE<br>APRIL 13/69  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ADATH ISRAEL ANSHE SFARD  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>APR 16 1969  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |  |

15120

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## VARIABLES

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH  
5-12-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05162

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05154

|  |                         |  |  |   |  |   |  |  |                                      |   |  |
|--|-------------------------|--|--|---|--|---|--|--|--------------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>CATHERINE</b>   |                         | First <b>S.</b>  |  | Middle <b>S.</b>  |  | Last <b>POOLEY</b>  |  | 20. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <b>April 12 1969</b> Month Day Year |                                      | 2b. HOUR <b>3:15</b> PM   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>May 21, 1909.</b>   |  | 6. AGE (In years<br>lost birthday)<br><b>59</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |                                      | 2c. DATE PRONOUNCED DEAD<br><b>April 12 1969</b> Month Day Year |  |
| 70. BIRTHPLACE (State or foreign<br>country) <b>Conn.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |  |                                      |   |  |
| 1D. CITY OR TOWN OF DEATH<br><b>Timonium</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address)<br><b>214 Sandee Drive</b> |  |   |  | 120. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |  |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>  |                         | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>214 Sandee Drive</b>  |                                      |   |  |
| 14. FATHER'S NAME<br><b>George F. Sheffer</b>  |                         |  |  | First Middle Last   |  | 15. MOTHER'S MAIDEN NAME<br><b>Millie Herbst</b>  |  |  |                                      | First Middle Last   |  |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                         | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. Elmer W. Pooley</b>   |  |  | ADDRESS<br>(Same)                    |   |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>869X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Excess ingestion of a mixture of alcohol,</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Phenobarbital &amp; Librium</b>                                 |                         |  |  |   |  |   |  |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |                         |  |  |   |  |   |  |  |                                      |   |  |
| 190. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                      |   |  |
| 210. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |                                      | State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |   |  |  |                                      |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>  |                         | EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>4/12/69</b>   |                                      | ADDRESS (Street, city, town, or county)                         |  |
| 230. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>4/15/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>   |                                      |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |                         |  |  |   |  | 250. REC'D BY REGISTRAR<br>DATE <b>APR 14 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                      |   |  |

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05155

|   |         |   |        |   |   |   |                           |                            |                                   |  |
|---|---------|---|--------|---|---|---|---------------------------|----------------------------|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   | Middle | Lost  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |   | Month                     | Day                        | Year                              | 2b. HOUR   |
| Larry   |         | Dwight  | PURKEY |   | 4   |   | 29                        | 1969                       | 8:45                              |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS                 |   | IF UNDER 24 HRS.<br>HOURS |                            | 2c. DATE PRONOUNCED DEAD<br>Month |  |
| Male  | White   | June 8, 1945  |        | 23 YRS.   |   |   |                           |                            | Day 29 Year 1969 8:45 AM          |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                           |                            |                                   |  |
| Maryland  |         | U.S.A.  |        |   |   | Baltimore   |                           |                            |                                   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)                 |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                           |                            |                                   |  |
| Owings Mills  |         | Rosewood State Hospital   |        | none  |   | ---   |                           |                            |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 13e. STREET AND NUMBER     |                                   |  |
| Maryland  |         | Baltimore   |        | Woodlawn  |   |   |                           | -----                      |                                   |  |
| 14. FATHER'S NAME   |         | First   | Middle | Lost  | 15. MOTHER'S MAIDEN NAME                  |   | First                     | Middle                     | Lost                              |  |
| Wiley   |         | -   | Purkey |   | Ella                                      |   | -                         | BRYANT                     |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |   | ADDRESS   |                           |                            |                                   |  |
| no  |         | -----   |        | Rosewood Records  |   | Owings Mills, Md. 21117   |                           |                            |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Disorder</u><br><u>2700</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Microcephaly</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Spastic quadriplegia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Phenylketonuria</u>                            |         |   |        |   |   |   |                           |                            |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>14 hrs.<br>25 yrs.<br>25 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none.</u>   |         |   |        |   |   |   |                           |                            |                                   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |        |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                           |                            |                                   |  |
| <u>none.</u>  |         |   |        |   |   |   |                           |                            |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING<br>CAUSE OF DEATH <u>none</u> <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                    |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><u>none</u>  |   |   |                           |                            |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br><u>none.</u> |        | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |                           | County                     |                                   | State  |
|   |         |   |        |   |   |   |                           |                            |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |        |   |   |   |                           |                            |                                   |  |
| ACTUAL<br>SIGNATURE <u>D. D. Caples</u>   |         | M.D.  |        |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                           | 22b. DATE SIGNED           |                                   |  |
| EXAMINER'S<br>NAME (Type)   |         | D.D.Caples, M.D.  |        |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |                           | 4-29-69                    |                                   |  |
|   |         |   |        |   |   | ADDRESS (Street, city, town, or county)   |                           | Reisterstown, Md.          |                                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |                           | (County)                   | (State)                           |  |
| Burial  |         | 5/1/69  |        | St. Johns   |   | Ellicott City   |                           | Howard                     | Md.                               |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS   |        |   |   | 25a. REC'D BY REGISTRAR   |                           | 25b. REGISTRAR'S SIGNATURE |                                   |  |
| Higinbotham Slack   |         | Ellicott City, Md.  |        |   |   | MAY 2 1969  |                           | <u>Charles Judge</u>       |                                   |  |

05162

UNITED STATES DEPARTMENT OF AGRICULTURE

|                                 |  |                                  |  |
|---------------------------------|--|----------------------------------|--|
| 1. NAME OF PERSON OR FIRM       |  | 2. ADDRESS                       |  |
| 3. CITY                         |  | 4. STATE                         |  |
| 5. ZIP CODE                     |  | 6. PHONE NUMBER                  |  |
| 7. TYPE OF BUSINESS             |  | 8. DATE OF ESTABLISHMENT         |  |
| 9. TYPE OF PRODUCT              |  | 10. QUANTITY PRODUCED            |  |
| 11. TYPE OF EQUIPMENT           |  | 12. TYPE OF MATERIALS            |  |
| 13. TYPE OF LABOR               |  | 14. TYPE OF CAPITAL              |  |
| 15. TYPE OF FINANCING           |  | 16. TYPE OF EXPORTS              |  |
| 17. TYPE OF IMPORTS             |  | 18. TYPE OF FOREIGN CURRENCY     |  |
| 19. TYPE OF FOREIGN TRADE       |  | 20. TYPE OF FOREIGN INVESTMENT   |  |
| 21. TYPE OF FOREIGN DEBT        |  | 22. TYPE OF FOREIGN RESERVES     |  |
| 23. TYPE OF FOREIGN EXCHANGE    |  | 24. TYPE OF FOREIGN INFLATION    |  |
| 25. TYPE OF FOREIGN INTEREST    |  | 26. TYPE OF FOREIGN RISK         |  |
| 27. TYPE OF FOREIGN POLICY      |  | 28. TYPE OF FOREIGN LEGISLATION  |  |
| 29. TYPE OF FOREIGN JUDICIARY   |  | 30. TYPE OF FOREIGN EXECUTIVE    |  |
| 31. TYPE OF FOREIGN LEGISLATIVE |  | 32. TYPE OF FOREIGN JUDICIAL     |  |
| 33. TYPE OF FOREIGN EXECUTIVE   |  | 34. TYPE OF FOREIGN LEGISLATIVE  |  |
| 35. TYPE OF FOREIGN JUDICIAL    |  | 36. TYPE OF FOREIGN EXECUTIVE    |  |
| 37. TYPE OF FOREIGN LEGISLATIVE |  | 38. TYPE OF FOREIGN JUDICIAL     |  |
| 39. TYPE OF FOREIGN EXECUTIVE   |  | 40. TYPE OF FOREIGN LEGISLATIVE  |  |
| 41. TYPE OF FOREIGN JUDICIAL    |  | 42. TYPE OF FOREIGN EXECUTIVE    |  |
| 43. TYPE OF FOREIGN LEGISLATIVE |  | 44. TYPE OF FOREIGN JUDICIAL     |  |
| 45. TYPE OF FOREIGN EXECUTIVE   |  | 46. TYPE OF FOREIGN LEGISLATIVE  |  |
| 47. TYPE OF FOREIGN JUDICIAL    |  | 48. TYPE OF FOREIGN EXECUTIVE    |  |
| 49. TYPE OF FOREIGN LEGISLATIVE |  | 50. TYPE OF FOREIGN JUDICIAL     |  |
| 51. TYPE OF FOREIGN EXECUTIVE   |  | 52. TYPE OF FOREIGN LEGISLATIVE  |  |
| 53. TYPE OF FOREIGN JUDICIAL    |  | 54. TYPE OF FOREIGN EXECUTIVE    |  |
| 55. TYPE OF FOREIGN LEGISLATIVE |  | 56. TYPE OF FOREIGN JUDICIAL     |  |
| 57. TYPE OF FOREIGN EXECUTIVE   |  | 58. TYPE OF FOREIGN LEGISLATIVE  |  |
| 59. TYPE OF FOREIGN JUDICIAL    |  | 60. TYPE OF FOREIGN EXECUTIVE    |  |
| 61. TYPE OF FOREIGN LEGISLATIVE |  | 62. TYPE OF FOREIGN JUDICIAL     |  |
| 63. TYPE OF FOREIGN EXECUTIVE   |  | 64. TYPE OF FOREIGN LEGISLATIVE  |  |
| 65. TYPE OF FOREIGN JUDICIAL    |  | 66. TYPE OF FOREIGN EXECUTIVE    |  |
| 67. TYPE OF FOREIGN LEGISLATIVE |  | 68. TYPE OF FOREIGN JUDICIAL     |  |
| 69. TYPE OF FOREIGN EXECUTIVE   |  | 70. TYPE OF FOREIGN LEGISLATIVE  |  |
| 71. TYPE OF FOREIGN JUDICIAL    |  | 72. TYPE OF FOREIGN EXECUTIVE    |  |
| 73. TYPE OF FOREIGN LEGISLATIVE |  | 74. TYPE OF FOREIGN JUDICIAL     |  |
| 75. TYPE OF FOREIGN EXECUTIVE   |  | 76. TYPE OF FOREIGN LEGISLATIVE  |  |
| 77. TYPE OF FOREIGN JUDICIAL    |  | 78. TYPE OF FOREIGN EXECUTIVE    |  |
| 79. TYPE OF FOREIGN LEGISLATIVE |  | 80. TYPE OF FOREIGN JUDICIAL     |  |
| 81. TYPE OF FOREIGN EXECUTIVE   |  | 82. TYPE OF FOREIGN LEGISLATIVE  |  |
| 83. TYPE OF FOREIGN JUDICIAL    |  | 84. TYPE OF FOREIGN EXECUTIVE    |  |
| 85. TYPE OF FOREIGN LEGISLATIVE |  | 86. TYPE OF FOREIGN JUDICIAL     |  |
| 87. TYPE OF FOREIGN EXECUTIVE   |  | 88. TYPE OF FOREIGN LEGISLATIVE  |  |
| 89. TYPE OF FOREIGN JUDICIAL    |  | 90. TYPE OF FOREIGN EXECUTIVE    |  |
| 91. TYPE OF FOREIGN LEGISLATIVE |  | 92. TYPE OF FOREIGN JUDICIAL     |  |
| 93. TYPE OF FOREIGN EXECUTIVE   |  | 94. TYPE OF FOREIGN LEGISLATIVE  |  |
| 95. TYPE OF FOREIGN JUDICIAL    |  | 96. TYPE OF FOREIGN EXECUTIVE    |  |
| 97. TYPE OF FOREIGN LEGISLATIVE |  | 98. TYPE OF FOREIGN JUDICIAL     |  |
| 99. TYPE OF FOREIGN EXECUTIVE   |  | 100. TYPE OF FOREIGN LEGISLATIVE |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |                        |  |
|--|--|--|--|---|---|---|--|--|------------------------|--|
| 05164  |  |  |  |   | 05156   |   |  |  |                        |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR   |                        |  |
| First Middle Last<br>SAMUEL RAFFEL   |  |  |  |   | Month Day Year<br>APRIL 8 1969  |   |  | 10 P M   |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS                                      |                        |  |
| MALE   |  | WHITE  |  | APRIL 20, 1900  |   | 68 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |                        |  |
| MARYLAND   |  | USA  |  |   |   | BALTIMORE Md.   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |                        |  |
|  |  |  | 7517 SLADE AVE   |   |   | SELF  |  | Books  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MARYLAND   |  |  | BALTIMORE  |   | BALTO   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 7517 SLADE AVE         |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |   |   |  |  |                        |  |
| MORRIS RAFFEL  |  |  | FANNIE RAFFEL  |   |   |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address  |  |                        |  |
| NO   |  |  | 212-03-5312  |   | MRS REBA RAFFEL   |   | SAME   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>art scl cv disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Few min<br>10 yr |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>none</u>  |  |  |  |   |   |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| <u>none</u>  |  |  |  |   |   |   |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |                        |  |
|  |  |  |  |   |   |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County State   |                        |  |
| <u>none</u>  |  |  |  |   |   |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>62</u> to <u>4/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |   |   |  |  |                        |  |
| 22b. SIGNATURE <u>Maurice Feldman</u> MD   |  |  |  | 22c. DATE SIGNED <u>4/8/69</u>  |   |   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <u>DR. MAURICE FELDMAN JR</u>   |  |  |  | 22e. ADDRESS <u>6610 CROSS COUNTRY</u>  |   |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| <u>BURIAL</u>  |  | <u>APRIL 11, 1969</u>  |  | <u>Bnai ISRAEL</u>  |   | <u>BALTO</u> <u>MD</u>  |  |  |                        |  |
| 24. FUNERAL DIRECTOR <u>Sylvan S. Lewis &amp; Son, Inc</u>   |  |  |  | 25a. REC'D BY REGISTRAR <u>APR 11 1969</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>   |  |  |                        |  |

08104

STATE OF NEW YORK

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |  |   |  |                           |
|--|--|--|--------------------------|---|--|--|---|--|---------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |  |   |  |                           |
| 05165 CERTIFICATE OF DEATH 05157   |  |  |                          |   |  |  |   |  |                           |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |   |  | 2a. DATE OF DEATH  |   |  | 2b. HOUR                  |
| FRANK D. RAILSBACK   |  |  |                          |   |  | April 25 1969  |   |  | 9:25 AM                   |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                           |
| Male   |  | White  |                          | January 25, 1885  |  | 84 YRS.  |   | IF UNDER 24 HRS<br>HOURS MIN   |                           |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |  | 10. CITY OR TOWN OF DEATH |
| Indiana  |  | U.S.A.   |                          |   |  | Baltimore  |   |  | Arbutus                   |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |   |  |                           |
| 1125 Linden Avenue   |  | Conductor  |                          | B & O R.R.  |  |  |   |  |                           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |                           |
| Maryland   |  | Howard   |                          | Dorsey  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |   | Box 417 Cedar Avenue   |                           |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |   |  |  |   |  |                           |
| First Middle Last  |  |  | First Middle Last        |   |  |  |   |  |                           |
| Jeremiah Railsback   |  |  | Elizabeth Bostock        |   |  |  |   |  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT   |  | Address  |   |  |                           |
| No   |  | 705-05-6167  |                          | Mrs. Mary D. Perrey, Box 417, Rt. 4   |  | 21227  |   |  |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic mitral regurgitation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Arteritis</u>            |  |  |                          |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 yrs</u><br><u>10 yrs</u> |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                          |   |  |  |   |  |                           |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                           |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                 |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |   |  |                           |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)            |                          | 21f. LOCATION   |  | Street or R.F.D. No.   |   | City or Town County State  |                           |
| 22a. I certify that (U) (this hospital) attended the deceased from Jan 1969, to Apr 25, 1969, that (U) (we) last<br>saw the deceased alive on Apr 25, 1969 and that in my (U) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (U) (we) (did) (did not) view the body after death. |  |  |                          |   |  |  |   |  |                           |
| 22b. SIGNATURE<br><u>Dr. Bruce Brumbaugh M.D.</u>  |  | 22c. DATE SIGNED<br><u>4/26/69</u>   |                          |   |  |  |   |  |                           |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS   |                          |   |  |  |   |  |                           |
| Dr. Bruce Brumbaugh  |  | 5609 Main Street, Elkridge, Maryland   |                          |   |  |  |   |  |                           |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |  |                           |
| BURIAL   |  | 4-29-1969  |                          | Meadowridge Cemetery  |  | Washington Blvd., Dorsey Md.   |   |  |                           |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |                          | 25a. REC'D BY REGISTRAR<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                           |
| Howard H. Hubbard, 4107 Wilkens Ave.   |  | 21227  |                          | APR 29 1969   |  | <u>Charles Judge</u>   |   |  |                           |



05165

22

WALTER D. BAKER

1910

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*[Faint, illegible handwritten text, possibly a signature or address]*

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 413  
5-17-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05166

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05158

|   |                  |  |  |   |                                |   |                                |   |  |   |                       |  |
|---|------------------|--|--|---|--------------------------------|---|--------------------------------|---|--|---|-----------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First<br>JOHN  |  | Middle<br>MILTON  |                                | Last<br>RICHARDS  |                                | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year<br><input checked="" type="checkbox"/> 19 |  | 2b. HOUR<br>M                                   |                       |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>Dec. 27, 1910  |  | 6. AGE (In years<br>last birthday)<br>58 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>April 30, 1969 |   | 2d. HOUR<br>4:20 P.M. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Utah  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |                                |   |  |   |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Penn Motel 8729  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Loch Bend Drive |  |   |                                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Executive |                                |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                         |   |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |                  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |                                | 13e. STREET AND NUMBER<br>801 Streambank Court  |  |   |                       |  |
| 14. FATHER'S NAME First Middle Last<br>Gomer M. Richards  |                  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sarah Butler  |                                |   |                                |   |  |   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br>579-03-1006   |                                | 17. INFORMANT<br>Mrs. Virginia Richards   |                                | ADDRESS<br>Same as # 13 E   |  |   |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial fibrosis and arteriolar sclerosis<br>428X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |  |   |                                |   |                                |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |  |   |                                |   |                                |   |  |   |                       |  |
| 19a. DATE OF OPERATION  |                  |  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |                                |   |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |                       |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |   |                                |   |  |   |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                    |  | 21f. LOCATION Street or R.F.D. No.  |                                | City or Town  |                                | County  |  | State   |                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |  |   |                                |   |                                |   |  |   |                       |  |
| ACTUAL<br>SIGNATURE<br>Charles S. Springate   |                  | M.D.<br>Charles S. Springate, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED<br>May 1, 1969                 |                       |  |
| EXAMINER'S<br>NAME (Type)   |                  | ADDRESS<br>(Street, city, town, or county)   |  |   |                                |   |                                |   |  |   |                       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                  | 23b. DATE<br>5-3-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |                                | 23d. LOCATION (City or Town)<br>Pikesville  |                                | (County)<br>Maryland  |  | (State)   |                       |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, Inc. Towson, Md.  |                  |  |  | ADDRESS   |                                | 25a. REC'D BY REGISTRAR<br>MAY 6 1969   |                                | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |                       |  |

02186

Dec. 22, 1910

Executive  
Ballston Township  
Gordon  
N. Richardson  
25-1000-000

Ballston Township, Inc. Town, Md.  
25-1000-000  
Gordon  
N. Richardson  
25-1000-000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 05167   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |  |   |  | 05159   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print) <sup>First</sup> GEORGE <sup>Middle</sup> FRANKLIN <sup>Last</sup> RICHARDSON  |  |  |  | 2a. DATE OF DEATH<br>April Month 28 Day 1969 Year   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>March 4, 1900   |  | 6. AGE (In years last birthday)<br>69 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Chesapeake Manor N. H. |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Acct. Baltimore City  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>4029 Belwood Avenue   |  | 14. FATHER'S NAME <sup>First</sup> George L. <sup>Middle</sup> Richardson <sup>Last</sup>              |  | 15. MOTHER'S MAIDEN NAME <sup>First</sup> Emma <sup>Middle</sup> Nuttrell <sup>Last</sup>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>No (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.<br>213-20-6745  |  | 17. INFORMANT<br>Mrs. Sarah R. Slotke, 2314 Killoran Rd. Baltimore, Md.   |  | Address 21093   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic brain syndrome</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Aortic aneurysm</u> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> , 1968, to <u>April 27</u> , 1969, that (I) (we) last saw the deceased alive on <u>March 26</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Donald O. Wood</u>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br>4-28-69   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DONALD O. WOOD, M.D.  |  |  |  | 22e. ADDRESS<br>York Road and Greenmeadow Dr., Timonium   |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)  |  | 23b. DATE<br>4-30-1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co., Maryland                        |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road, 21204   |  |  |  | 25a. REC'D BY REGISTRAR<br>APR 30 1969  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

70120

UNITED STATES DEPARTMENT OF THE ARMY

HEADQUARTERS, ARMY MEDICAL DEPARTMENT

WASHINGTON, D. C. 20315

1. PURPOSE AND SCOPE

2. REFERENCES

3. DEFINITIONS

4. ORGANIZATION

5. PROCEDURES

6. APPENDICES

7. REFERENCES

8. APPENDICES

9. REFERENCES

10. APPENDICES

11. REFERENCES

12. APPENDICES

13. REFERENCES

14. APPENDICES

15. REFERENCES

16. APPENDICES

17. REFERENCES

18. APPENDICES

19. REFERENCES

20. APPENDICES

21. REFERENCES

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VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                       |  |  |  |                                   |  |  |  |
|--|--|---------------------------------------|--|--|--|-----------------------------------|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                       |  |  |  |                                   |  |  |  |
| Item 23 Film 411 4/10/69 kk  |  |                                       |  |  | CERTIFICATE OF DEATH   |                                   |  |  |  |
| 05168  |  |                                       |  |  | 05160  |                                   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>CATONSVILLE</u> MARYLAND   |  |                                       |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |                                   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u>  |  |                                       | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeland - B.C.T.</u>                                    |                                   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u> 329 Harlem Lane   |  |                                       |  |  | d. STREET ADDRESS <u>3103 Savoy St. 21230</u>  |                                   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>CARRIE E. Riedel</u>  |  |                                       |  |  | 4. DATE OF DEATH <u>APRIL 1 1969</u>   |                                   |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1-12-1895</u> |  | 9. AGE (In years last birthday) <u>74</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>   |                                   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Samuel Lanthicum</u>  |  |                                       |  |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Russell</u>   |                                   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                                       | 16. SOCIAL SECURITY NO. <u>212-09-8817</u>   |  | 17. INFORMANT <u>Catherine Donlan</u> Address <u>3103 Savoy St #30</u>   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CVA c Hemiparesis</u><br>4329 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Middle Cerebral artery thrombosis</u><br>DUE TO (c)                            |  |                                       |  |  |  |                                   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis - Chronic Brain Syndrome</u>  |  |                                       |  |  |  |                                   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |                                   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)                                       |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3-10-</u> , 196 <u>9</u> , to <u>4-1-</u> , 196 <u>9</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4-1-</u> , 196 <u>9</u> , and that death occurred at <u>6 P.</u> M, from causes on and on the date stated above. |  |                                       |  |  |  |                                   |  |  |  |
| 22a. SIGNATURE <u>Cesar Valle Cervero</u> M.D.   |  |                                       |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |                                   | 22b. DATE SIGNED <u>4-2-69</u>   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CERVERO</u>  |  |                                       |  |  | 22d. ADDRESS <u>3629 Liberty Rd</u>  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Apr. 5, 1969</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Pk</u>  |  |                                   | 23d. LOCATION (City or Town) (County) (State) <u>Dorsey Howard Co. Md.</u> |  |  |
| 24. FUNERAL DIRECTOR <u>McCully</u> 337 Potomac Ave, 21225   |  |                                       |  |  | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                            |  |  |
| DATE <u>APR 7 1969</u>   |  |                                       |  |  |  |                                   |  |  |  |

RECEIVED

2003

2003



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                          |  |  |  |
|--|--|--|--|--|--|---|--|--------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                          |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                          |  |  |  |
| 05169  |  | 05161  |  |  |  |   |  |                          |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  | First  |  | Middle   |  | Last  |  | 2a. DATE OF DEATH        |  | 2b. HOUR   |  |
| LULA   |  | ANNA   |  | RILL   |  | APRIL 29 1969   |  | 11:05                    |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)                                     |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.   |  |
| Female   |  | White  |  | March 28, 1884   |  | 85 YRS.   |  | MONTHS                   |  | DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                          |  |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore   |  |                          |  |  |  |
| 1d. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                          |  |  |  |
| HAMPSTEAD  |  | Falls Road   |  | Housewife  |  | Home  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER  |  |                          |  |  |  |
| Maryland   |  | Baltimore  |  | HAMPSTEAD  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Rt 2 Falls Road          |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME |  | First  |  |
| Joseph   |  | DAVIDSON   |  |  |  |   |  | Iowa                     |  | BROWN  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address   |  |                          |  |  |  |
| No   |  | 213-36-7870  |  | Mrs Earl Martin  |  | HAMPSTEAD Md  |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |                          |  |  |  |
| IMMEDIATE CAUSE (a) 4124   |  |  |  |  |  |   |  |                          |  | 7 Days   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Central Atherosclerosis   |  |  |  |  |  |   |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Cardiovascular disease  |  |  |  |  |  |   |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |                          |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |   |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |
|  |  |  |  |  |  |   |  |                          |  |  |  |
| 20a. AUTOPSY?  |  |  |  |  |  |   |  |                          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |   |  |                          |  | 21b. TIME OF INJURY  |  |
|  |  |  |  |  |  |   |  |                          |  | HOUR A.M. Month Day Year   |  |
|  |  |  |  |  |  |   |  |                          |  | P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |                          |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |   |  |                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/>  |  |  |  |  |  |   |  |                          |  |  |  |
| at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |   |  |                          |  |  |  |
| 21f. LOCATION  |  |  |  |  |  |   |  |                          |  | Street or R.F.D. No. City or Town County State                               |  |
|  |  |  |  |  |  |   |  |                          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12, 1966, to April 29, 1969, that (I) (we) lost saw the deceased alive on April 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                          |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  |                          |  | 22c. DATE SIGNED   |  |
| Joseph E. Bush M.D.  |  |  |  |  |  |   |  |                          |  | April 29, 1969   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |   |  |                          |  | 22e. ADDRESS   |  |
| Joseph E. Bush M.D.  |  |  |  |  |  |   |  |                          |  | HAMPSTEAD Maryland   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |   |  |                          |  | 23b. DATE  |  |
| Burial   |  |  |  |  |  |   |  |                          |  | 5/2/69   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |   |  |                          |  | 23d. LOCATION (City or Town) (County) (State)                                |  |
| Wesley Cemetery  |  |  |  |  |  |   |  |                          |  | Hampstead Md.  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  |                          |  | 25a. REC'D BY REGISTRAR  |  |
| Tipton-Eline Fun.Home Hampstead, Md.   |  |  |  |  |  |   |  |                          |  | MAY 5 1969   |  |
|  |  |  |  |  |  |   |  |                          |  | 25b. REGISTRAR'S SIGNATURE   |  |
|  |  |  |  |  |  |   |  |                          |  |  |  |

08120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
|--|--|--|--|--|--|---|--|---|---|--|--------------------------------|-------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
| 05170 CERTIFICATE OF DEATH 05162   |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |  | Middle   |   | Last   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                       |                   |  |  |
| TOMMIE   |  |  | -  |  | -  |   | RISHER   |   | APRIL 20, 1969  |  | 5:30 AM                        |                   |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                   |  |  |
| MALE   |  |  | NEGRO  |  |  | 4/13/13   |  |   | 36 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN. |                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH  |  |                                |                   |  |  |
| S. CAROLINA  |  |  | U.S.A.   |  |  |   |  |   | BALTIMORE Md.   |  |                                |                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |                   |  |  |
| FORT HOWARD,   |  |  | VETERANS ADMIN. HOSPITAL   |  |  | LABORER   |  |   | STEEL   |  |                                |                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |                                |                   |  |  |
| MARYLAND   |  |  |  |  |  | BALTIMORE   |  |   |   | 1720 E. OLIVER STREET  |                                |                   |  |  |
| 14. FATHER'S NAME  |  |  | First  |  | Middle   |   | Last   |   | 15. MOTHER'S MAIDEN NAME  |  |                                | First Middle Last |  |  |
| JIM  |  |  | -  |  | -  |   | RISHER   |   | MARY  |  |                                | - - PRIECE        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |   |   |  |                                |                   |  |  |
| YES  |  |  | WWII   |  |  | 215 10 4987   |  |   | CLINICAL RECORDS, VAH, FT. HOWARD, MD.                                      |  |                                |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1630 CARCINOMA OF LEFT PLEURA WITH EXTENSIVE METASTASIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS<br>YEARS |                                |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |  |                                |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |                                |                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |                                |                   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from APR 15, 1969, to APR 20, 1969, that (X) (we) last saw the deceased alive on APR 20, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
| 22b. SIGNATURE<br>Pushpendra Senan   |  |  | 22c. DATE SIGNED<br>4 20 69  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>PUSHPENDRA SENAN, M.D.  |  |   |   |  |                                |                   |  |  |
| 22e. ADDRESS<br>VAH, FT. HOWARD, MD.   |  |  |  |  |  |   |  |   |   |  |                                |                   |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)   |  |  | 23b. DATE<br>April 25/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. NATIONAL CEMETERY |   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MD.                                 |   |  |                                |                   |  |  |
| 24. FUNERAL DIRECTOR<br>ELLIOTT FUNERAL HOME   |  |  | 24a. ADDRESS<br>1129 N. CAROLINE ST.,<br>BALTO., MD.                         |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 21 1969   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                 |  |                                |                   |  |  |

05170

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE CHIEF OF BUREAU

DATE: APRIL 20, 1942

TO: THE CHIEF OF BUREAU

FROM: THE CHIEF OF BUREAU

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

05171

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05163

|   |         |  |                  |   |                                 |  |                        |                        |      |
|---|---------|--|------------------|---|---------------------------------|--|------------------------|------------------------|------|
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Last  | 20. DATE OF DEATH               |  | 2b. HOUR               |                        |      |
| JOSEPH  |         |  |                  | ROCKLIN   | APRIL 8, 1969                   |  | 6 A.M.                 |                        |      |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR        |                        |      |
| MALE  | WHITE   |  | 9-10-1914        |   | 54 YRS.                         |  | MONTHS DAYS HOURS MIN. |                        |      |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH   |                        | Md.                    |      |
| BALTO., MD.   |         | U.S.A.   |                  |   |                                 | BALTIMORE  |                        |                        |      |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |                        |      |
| B ALTIMORE  |         | 3317 OLD POST DRIVE  |                  | CPA   |                                 | SELF EMPLOYED  |                        |                        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        | 13e. STREET AND NUMBER |      |
| MARYLAND  |         | BALTIMORE  |                  |   |                                 |  |                        | 3317 OLD POST DRIVE    |      |
| 14. FATHER'S NAME   |         | First  | Middle           | Last  | 15. MOTHER'S MAIDEN NAME        |  | First                  | Middle                 | Last |
| ABRAHAM ROCKKIND  |         |  |                  |   | REBECCA                         |  |                        |                        | ?    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |                                 | Address  |                        |                        |      |
| YES   |         | W.W. II  |                  | MRS. GERTIE ROCKKLIN,   |                                 | 3317 OLD POST DR. #8   |                        |                        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic CV disease - acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> |         |  |                  |   |                                 |  |                        |                        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Acute myocardial infarction 1962 - Sinai Hospital</u>   |         |  |                  |   |                                 |  |                        |                        |      |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                        |                        |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                 |  |                        |                        |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |  |                        |                        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>4/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |         |  |                  |   |                                 |  |                        |                        |      |
| 22b. SIGNATURE<br><u>Abraham Genecin M.D.</u>   |         |  |                  | 22c. DATE SIGNED<br><u>8 April 69</u>   |                                 |  |                        |                        |      |
| 22d. PHYSICIAN'S NAME (Type)<br>ABRAHAM GENECIN   |         |  |                  | 22e. ADDRESS<br>611 PARK AVENUE   |                                 |  |                        |                        |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)  |                        |                        |      |
| BURIAL  |         | 4-8-69   |                  | ARLINGTON   |                                 | BALTIMORE, MARYLAND  |                        |                        |      |
| 24. FUNERAL DIRECTOR  |         |  |                  | 25a. REC'D BY REGISTRAR   |                                 | 25b. REGISTRAR'S SIGNATURE   |                        |                        |      |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |         |  |                  | APR 9 1969  |                                 | <u>[Signature]</u>   |                        |                        |      |

08131

RECORDS OF DEATH

1921

1921

1921

1921

DATE

WHITE

1-1-1921

BALTIMORE

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BALTIMORE

BALTIMORE

311 OLD BAY STREET

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311 OLD BAY STREET

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BALTIMORE

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ADMINISTRATIVE

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311 OLD BAY STREET

ADMINISTRATIVE

1-1-1921

BALTIMORE

BALTIMORE

311 OLD BAY STREET, BALTIMORE



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 05172  |  |  |  |   |  |   |  |   |  |
| 05164  |  |  |  |   |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED-NAME (Type or Print) First Middle Last<br>MARTHA BRAYSHAW Roof   |  |  |  |   |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year<br>April 6 1969 |  | 2b. HOUR<br>7:24 PM   |  |
| 3. SEX<br>F  |  | 4. RACE<br>Cau   |  | 5. DATE OF BIRTH<br>2-22-10   |  | 6. AGE (In years last birthday)<br>59 YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>April 6 1969  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Penna   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>2 W. Penna. Ave   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Hickam |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.   |  |  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>Phoenix  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME First Middle Last<br>Orlando Brayshaw  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>MARY E CRUMICK  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>no   |  |  |  | 16b. SOCIAL SECURITY NO.<br>2532-158  |  | 17. INFORMANT ADDRESS<br>Kusell T Prof - Same as #13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>4100</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>14 Yr              |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Charles F O'Donnell  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |  |
| EXAMINER'S NAME (Type)   |  |  |  | ADDRESS (Street, city, town, or county)   |  | 22b. DATE SIGNED<br>4/6/69  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation   |  | 23b. DATE<br>4-7-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cork. Birch Town   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 10 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |

01113

RECEIVED JAN 23 1964

U.S. DEPARTMENT OF AGRICULTURE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20250

RECEIVED  
JAN 23 1964

U.S. DEPARTMENT OF AGRICULTURE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20250

05173

CERTIFICATE OF DEATH

05165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| Rosie   |  | Rose   |  |  |  |   |  | April 15, 1969   |  | 7:10 a. M.                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                              |  |
| female  |  | Negro  |  | Aug. 8, 1883   |  |   |  | 85 YRS.  |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |  |  |
| Md.   |  | U. S.  |  |  |  | Baltimore   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| Catonsville   |  | SPRING GROVE STATE HOSP.   |  |  |  | housewife   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER   |  |  |  |
| Md.   |  | Harford  |  | Belair   |  |   |  | 106 Garden Street  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |  |  |  |  |
| Williams  |  |  |  | Julian   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address   |  |  |  |  |  |
|   |  | 219-36-2481A   |  | Records: SPRING GROVE STATE HOSPITAL   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |  |  |  |  |  |   |  |  |  |  |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| Urinary tract infection; uremia; late, latent syphilis; decubitus ulcers  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |   |  |  |  |  |  |
|   |  | 19   |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 28, 1968, to April 15, 1969, that (I) (we) saw the deceased alive on April 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | Diomidis Pirovolidis, M.D.   |  |  |  | 22c. DATE SIGNED  |  | 4-15-69  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |  |
| APRIL 18-69   |  | APRIL 18-69  |  | Henderson Hill   |  | Bel Air Md  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  | George W. Tittle, Bel Air Md   |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
|   |  |  |  |  |  | APR 17 1969   |  | Charles Judge  |  |  |  |

05173

RECEIVED

APR 17 1955

1955

1955

U. S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY

ADMINISTRATIVE

ADMINISTRATIVE

1955-10-01

Administrative Services Division

Washington, D. C.

Subject: [illegible]

DATE

TIME

APR 17 1955

1955

XX

APR 17 1955

1955

1955-10-01

ADMINISTRATIVE SERVICES DIVISION

WASHINGTON, D. C.

RECEIVED

APR 17 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05174  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05166  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| ARTHUR WILHELM ROSENBERGER   |  |  |  |  |  |  |  |  |  | APRIL 28 1969  |  |  |  |  |  |  |  |  |  | 16 45 a M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR        |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Male   |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | 22 March 1897  |  |  |  |  |  |  |  |  |  | 72 YRS.  |  |  |  |  |  |  |  |  |  | MONTHS                 |  |  |  |  |  |  |  |  |  | DAYS             |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Germany  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Baltimore  |  |  |  |  |  |  |  |  |  | 6724 Townbrook Dr  |  |  |  |  |  |  |  |  |  | Ret  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Md   |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 6724 Townbrook Dr      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Leo  |  |  |  |  |  |  |  |  |  | ROSENBERGER  |  |  |  |  |  |  |  |  |  | Herwig   |  |  |  |  |  |  |  |  |  | Rosenberger  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| NO   |  |  |  |  |  |  |  |  |  | (If yes give war or dates of service)  |  |  |  |  |  |  |  |  |  | 218-140644   |  |  |  |  |  |  |  |  |  | Wife   |  |  |  |  |  |  |  |  |  | Same                   |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | Hypertensive cardio-vascular disease   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 15 years   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 2509   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | (b) Diabetes mellitus  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Kurt Mursbaum M.D.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 207 Clarendon Ave  |  |  |  |  |  |  |  |  |  | 21208  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 4/29/1969  |  |  |  |  |  |  |  |  |  | Chesapeake Chesapeake  |  |  |  |  |  |  |  |  |  | Randallstown Md  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DIED BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Sydney S. Quissason  |  |  |  |  |  |  |  |  |  | 9610 Reisterstown Rd   |  |  |  |  |  |  |  |  |  | APR 29 1969  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |



05174

RECEIVED

1931



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |   |  |  |  |  |  |
|---|--|---|---|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |   |  |  |  |  |  |
| 05175 CERTIFICATE OF DEATH 05167  |  |   |   |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) Margaret Cecelia Ryan   |  |   | 2a. DATE OF DEATH<br>April Month 9 Day 1969 Year              |   |  | 2b. HOUR<br>1:15 P.   |  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>11-20-1882  |  | 6. AGE (In years last birthday)<br>86 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph's Hospital |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Carl Home  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Riderwood  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1622 W. Joppa Road |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>William Ryan   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Margaret Howard |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, (unknown) No   |  | (If yes give war or dates of service) None  |   | 16b. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMANT<br>Family records Address   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis<br>433.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) General arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Congestive heart failure secondary to arteriosclerotic cardiovascular disease |  |   |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 4, 1969, to April 9, 1969, that (I) (we) last saw the deceased alive on April 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>N. Kunawongsa   |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br>4-9-69  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Nit Kunawongsa, M.D.   |  |   |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, OR DISPOSITION<br>Burial  |  | 23b. DATE<br>April 11, 1969   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Memorial   |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Maryland                         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>John Bulno Sons   |  |   |   | ADDRESS<br>Towson   |  | 25a. REC'D BY REGISTRAR<br>APR 14 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>William Judge  |  |  |  |

05175

Location

Intersect

Intersect

William Penn

Early records

none

none

no

Printed

April 11, 1959 (revised) by (revised) (revised)

1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05176

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05168

|  |  |  |   |  |  |   |  |  |  |                             |
|--|--|--|---|--|--|---|--|--|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) <i>William George Saddington</i>  |  |  |   |  |  | 2a. DATE OF DEATH <i>April 1</i> Month <i>29</i> Day <i>1969</i> Year   |  |  | 2b. HOUR <i>4:00</i> AM                            |                             |
| 3. SEX <i>Male</i>   |  | 4. RACE <i>W</i>   |   | 5. DATE OF BIRTH <i>Dec. 9 1905</i>  |  | 6. AGE (In years last birthday) <i>63</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>PA.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>KINGSVILLE</i>  |  | Baltimore Md.  |  |                             |
| 10. CITY OR TOWN OF DEATH <i>Kingsville</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kingsville Md.</i> |   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>craftsman</i>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>MTD</i>                         |  |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |  |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN <i>Kingsville</i>    |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <i>Bellvue Avenue 21087</i> |                             |
| 14. FATHER'S NAME First <i>William</i> Middle <i>Marion</i> Last <i>Saddington</i>   |  |  | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Harrison</i> Last |  |  |   |  |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <i>No</i>   |  |  | 16b. SOCIAL SECURITY NO. <i>163-09-0545</i>                                 |  | 17. INFORMANT <i>Mariam Saddington</i> |   |  | Address <i>Kingsville Md. Bellvue Ave.</i>                           |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic CVD</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immediate</i><br><i>8 yrs. +</i> |  |  |   |  |  |   |  |  |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |   |  |  |  |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1959</i> , to <i>April 1, 1969</i> , that (I) (we) lost the deceased on <i>April 1, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |                             |
| 22b. SIGNATURE <i>William A. Tyson M.D.</i>  |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <i>4-29-69</i>                                      |  |                             |
| 22d. PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>   |  |  |   |  |  | 22e. ADDRESS <i>Kingsville, Md.</i>   |  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <i>5/2/69</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Belair Memorial</i>  |  | 23d. LOCATION (City or Town) (County) (State) <i>Bel Air Md.</i>  |  |  |  |                             |
| 24. FUNERAL DIRECTOR <i>Sessaba Turner Home</i>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>James Judge</i>                        |  |                             |

25120

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 05177  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 05169   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>EARL WASHINGTON SANTMYERS</b>  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>69</b>   |  |  |  |  |   |  |  |  |  | 2b. HOUR <b>12:45</b> M   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>M</b>  |  |  |  |  | 4. RACE <b>Cauc</b>   |  |  |  |  | 5. DATE OF BIRTH <b>3-11-93</b>  |  |  |  |  | 6. AGE (In years last birthday) <b>76</b> YRS.                                    |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS   |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto Co Gen Hosp</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Md.</b>   |  |  |  |  | 13b. COUNTY <b>Balto</b>  |  |  |  |  | 13c. CITY OR TOWN <b>Balto</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER <b>710 Templecliff Rd.</b>                                 |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME <b>Washington</b> First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <b>Emma Fischer</b> First Middle Last  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral aneurysm, post metastatic</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 mos 1 year?</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>Dec 68</b>   |  |  |  |  |   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of lung</b>   |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |                             |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.  |  |  |  |  |   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |   |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 1968</b> , to <b>Apr 8, 1969</b> , that (I) (we) last saw the deceased alive on <b>Apr 5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>H. Gerard Oster MD</b>   |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED <b>4/8/69</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>H. Gerard Oster</b>  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS <b>6821 Reisterstown Rd</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Charles Judge</b>  |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>APR 9 1969</b>  |  |  |  |  |   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

UNITED STATES OF AMERICA

7-11-59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |  |   |   |   |  |  |  |
|--|--|------------------------------|--|---|--|---|---|---|--|--|--|
| 05178  |  | CERTIFICATE OF DEATH         |  |   |  |   |   | 05170   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |   |   | 2b. HOUR P.<br>1:25 M  |  |  |
| ANDERSON   |  |                              | McCLELLAN SAVOY  |   |  | April 1 1969  |   |   |  |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  |  |
| Male   |  | Negro                        |  | Oct. 11. 1897   |  |   | 71 YRS.   |   | IF UNDER 24 HRS.<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Md.   |   |  |  |  |
| MARYLAND   |  | U.S.A.                       |  |   |  |   | BALTIMORE   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| FORT HOWARD  |  |                              | VETERANS ADMINISTRATION HOSPITAL   |   |  | Handyman  |   |   | Private Family   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |  |  |
| MARYLAND   |  |                              | BALTO  |   | BALTIMORE  |   |   |   | 12 Jones Avenue  |  |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |  |   |   |   |  |  |  |
| WILLIAM H. SAVOY   |  |                              | EMMA A. WASHINGTON   |   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address                                 |   |   |   |  |  |  |
| YES  |  |                              | WW-1   |   | 705 10 3231 Clinical Rcds, VA Hospital, Fort Howard, Md. |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, RECENT</u>  |  |                              |  |   |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY EMPHYSEMA, OLD</u>  |  |                              |  |   |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                              |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>ADENOCARCINOMA OF PROSTATE, OLD</u>   |  |                              |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Feb. 24</u> , 19 <u>69</u> , to <u>April 1</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>April 1</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (dissect/view the body after death). |  |                              |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Edward C. Kramer</u>  |  |                              |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>4/2/69  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>EDWARD C. KRAMER, M.D.   |  |                              |  |   |  | 22e. ADDRESS<br>VA Hospital, Fort Howard, Maryland  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |                              | 23b. DATE<br>4-4-69  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>   |  |                              | ADDRESS<br>Md.   |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 7 1969  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                          |  |  |  |
| SNOWDEN FUNERAL HOME 246 N. Wash. St. Rockville, Md.   |  |                              |  |   |  |   |   |   |  |  |  |

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*Received 12 June 2002; accepted 12 July 2002*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05179MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05171

|  |  |                                     |   |   |                                |   |   |   |   |   |                   |  |
|--|--|-------------------------------------|---|---|--------------------------------|---|---|---|---|---|-------------------|--|
| 1. DECEASED-NAME<br>(Type or print) Anna   |  |                                     | First   | Middle  | Last                           | 2a. DATE OF DEATH<br>April Month 17 Day 1969.   |   |   | 2b. HOUR<br>5 <sup>15</sup> 4 M   |   |                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White                    |   | 5. DATE OF BIRTH<br>Dec. 23, 1879.  |                                |   | 6. AGE (In years<br>last birthday)<br>89 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                |   |                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |   | 9. COUNTY OF DEATH<br>Baltimore, Md.  |   |   |   |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore (Rural)   |  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Armcast Nursing Home |   |                                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.   |  |                                     | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>8401 Loch Raven Blvd.                         |   |                   |  |
| 14. FATHER'S NAME<br>Frederick W. Feldner  |  |                                     | First   | Middle  | Last                           | 15. MOTHER'S MAIDEN NAME<br>Elizabeth Hoehne  |   |   | First   | Middle  | Last              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  |                                     | (If yes give war or dates of service)   |   |                                | 16b. SOCIAL SECURITY NO.<br>220-44-0092   |   | 17. INFORMANT<br>Mr. Charles Feldner  |   |   | Address<br>(Same) |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                     |   |   |                                |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 hrs<br>9 yrs. |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Severe arteriosclerotic cerebrovascular disease   |  |                                     |   |   |                                |   |   |   |   |   |                   |  |
| 19a. DATE OF OPERATION   |  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                         |   |   |   |   |                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |   |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec, 1958, to April 17, 1969, that (I) (we) last saw the deceased alive on April 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (the) view the body after death.   |  |                                     |   |   |                                |   |   |   |   |   |                   |  |
| 22b. SIGNATURE<br>Joseph F. LiPira MD  |  |                                     |   |   |                                | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-18-69   |                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Joseph F. LiPira MD  |  |                                     |   |   |                                | 22e. ADDRESS<br>8401 Loch Raven Blvd. Balto, Md. 21204  |   |   |   |   |                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |                                     | 23b. DATE<br>4/21/69.   |   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Mausoleum  |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.         |   |                   |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214   |  |                                     |   |   |                                | 25a. REGD. BY REGISTRAR<br>APR 21 1969  |   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |   |                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
|--|--|--|--|--|----------|---|------|--|-----------------------------------|--|----------|------------------|--|
| 05180  |  | CERTIFICATE OF DEATH   |  |  |          |   |      | 05172  |                                   |  |          |                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |  | Middle   |   | Last |  | 2a. DATE OF DEATH                 |  | 2b. HOUR |                  |  |
| JAMES  |  |  | E.   |  | SCHIRMER |   |      |  | 4 Month 14 Day 69 Year            |  | 7:40 M   |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |          |   |      | 6. AGE (In years last birthday)  |                                   | IF UNDER 1 YEAR                              |          | IF UNDER 24 HRS. |  |
| Male   |  | Cau.   |  | 4-3-1908   |          |   |      | 61 YRS.  |                                   | MONTHS                                       |          | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. COUNTY OF DEATH  |      |  |                                   |  |          |                  |  |
| Baltimore  |  | U.S.A.   |  |  |          | Baltimore Md.   |      |  |                                   |  |          |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |                  |  |
| Towson   |  |  | Greater Balto. Med. Center   |  |          | Ret. Postal Mechanic  |      |  | Postoffice                        |  |          |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |          | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |          |                  |  |
| Md.  |  |  | Baltimore  |  |          | Towson  |      |  |                                   | 5601 Leiden Road 21206                       |          |                  |  |
| 14. FATHER'S NAME  |  |  | First  |  | Middle   |   | Last |  | 15. MOTHER'S MAIDEN NAME          |  |          |                  |  |
| Anthony  |  |  | Schirmer   |  |          |   |      |  | Anna Spahn                        |  |          |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |          | 17. INFORMANT Address   |      |  |                                   |  |          |                  |  |
| No   |  |  | 215-03-8217  |  |          | Mrs Marion Schirmer 5601 Leider Avenue 06   |      |  |                                   |  |          |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |          |   |      |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| IMMEDIATE CAUSE (a) Congestive heart failure   |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease   |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |          | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |                                   |  |          |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |          |   |      |  |                                   |  |          |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |          | City or Town  |      | County   |                                   | State  |          |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/1969, to 4/14/1969, that (I) (we) last saw the deceased alive on 4/14/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |          |   |      |  |                                   |  |          |                  |  |
| 22b. SIGNATURE   |  | Charles C. Brown, M.D., DEGREE   |  |  |          | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |      | 22c. DATE SIGNED 4/14/69   |                                   |  |          |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | Charles C. Brown, M.D.   |  |  |          | 22e. ADDRESS 6701 N. Charles Street   |      |  |                                   |  |          |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |          | 23d. LOCATION (City or Town)  |      | (County)   |                                   | (State)                                      |          |                  |  |
| Burial   |  | 4-17-1969  |  | Gardens of Faith   |          | Fullerton   |      | Balto.   |                                   | Md.  |          |                  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  |  |          | 25a. REC'D BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE   |                                   |  |          |                  |  |
| Lassahn Funeral Home   |  | 7401 Belair Road 21236   |  |  |          | DATE APR 16 1969  |      | Charles Judge  |                                   |  |          |                  |  |

05130

THE PEOPLE OF THE UNITED STATES

UNITED STATES DEPARTMENT OF JUSTICE

1964-1965

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05181

05173

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>LOUIS STANFORD SCHLOSS</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>19</b> Year <b>1969</b> |   |   | 2b. HOUR<br><b>1:30</b> PM   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>12-1-1916</b>  |   | 6. AGE (In years last birthday)<br><b>52</b> YRS.                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>KEYSER &amp; TOPPING ROADS</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>EXECUTIVE</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SURPLUS</b>              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>KEYSER &amp; TOPPING RDS.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>MOSES SCHLOSS</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SOPHIA ?</b>          |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>MRS. MURIAL SCHLOSS, KEYSER &amp; TOPPING RDS.</b>                              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1538</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Colon metastatic to liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>none</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>none</b> |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 months</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>none</b>   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1968</b> , to <b>April 19, 1969</b> , that (I) ( <del>we</del> ) lost the deceased alive on <b>April 19, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.        |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Manuel Levin</b>  |  |   |  | 22c. DATE SIGNED<br><b>4/19/69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>MANUEL LEVIN, M.D.</b>                      |  |  |  |
| 22e. ADDRESS<br><b>6101 PARK HILLS AVE, BALTO-15 MD</b>  |  |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-21-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>REISTERSTOWN, MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 23 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                             |  |  |  |

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Page 28

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05182

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05174

|   |                  |   |   |   |   |
|---|------------------|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>SIDNEY SCHLOSS  |                  |   | 2a. DATE OF DEATH<br>Month Day Year<br>APRIL 30, 1969 |   | 2b. HOUR<br>9 A.M.  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE |   | 5. DATE OF BIRTH<br>APRIL 3, 1913                     |   | 6. AGE (In years<br>last birthday)<br>56 YRS.                       |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BALTIMORE, MD.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH<br>BALTIMORE   |                  | Md.   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>3215 MIDFIELD ROAD |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>PROPRIETOR DELICATESSEN STORE                                 |   |
| 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                  |   |   |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |                  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE  |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                  | 13e. STREET AND NUMBER<br>3215 MIDFIELD ROAD  |   |   |   |
| 14. FATHER'S NAME<br>First Middle Last<br>DAVID SCHLOSS   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>SARAH ?  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>NO  |                  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br>MRS. FANNIE SCHLOSS, 3215 MIDFIELD ROAD #8  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>4123 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Repeat myocardial infarctions</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pituitary cell carcinoma</u> |                  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 yr<br>14-5 yrs |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1958, to April 30, 1969, that (I) (we) last saw the deceased alive on 4/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |   |   |   |   |
| 22b. SIGNATURE<br>Joseph C. Matchar MD  |                  | 22c. DATE SIGNED<br>4/30/69   |   | 22d. PHYSICIAN'S<br>NAME (Type) JOSEPH C. MATCHAR   |   |
| 22e. ADDRESS<br>6821 REISTERSTOWN ROAD  |                  |   |   |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |                  | 23b. DATE<br>5-1-69   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI TFILOH  |   |
| 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND  |                  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |                  | 25a. REC'D BY REGISTRAR<br>DATE MAY 2 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>J. J. Judge   |   |

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STATE OF TEXAS

COUNTY OF DALLAS

DATE

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NOTARY PUBLIC

NOTARY PUBLIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
| 05183   |  |  |  |   | 05175  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |   | 2a. DATE OF DEATH  |  |  |  |  |
| First Middle Last<br><b>Samuel A. Schmidt</b>   |  |  |  |   | Month Day Year<br><b>April 15, 1969</b>  |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>October 15, 1887</b>   |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.                                  |  | 2b. HOUR<br><b>M</b>                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Liberty &amp; Robeson Roads</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Owner</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Auto</b>                            |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Randallstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>9105 Liberty Road</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Schmidt</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth Kennell</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> No   |  | 16b. SOCIAL SECURITY NO.<br><b>212-16-4045</b>   |  | 17. INFORMANT Address<br><b>Virginia D. Mettam 9105 Liberty Road</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4369</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CVA &amp; Hemiplegia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-22-1969</b> , to <b>4-14-1969</b> , that (I) (we) last saw the deceased alive on <b>4-14-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Cavero</b>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Cesar Cavero</b>   |  |  |  |   | 22e. ADDRESS<br><b>8629 Liberty Road</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/18/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown Baltimore Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Loring Byers Chapel 8728 Liberty Road 21133</b>  |  |  |  |   | 25a. REC'D BY REGISTRAR<br><b>APR 21 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Yundt</b>                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 05184  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05176  |  |
| 1. DECEASED-NAME (Type or print) <b>CLARENCE OSCAR SCHOAL</b>  |  |  |  |  |  | 2a. DATE OF DEATH <b>April 22 1969</b>   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>4/13/02</b>  |  | 2b. HOUR <b>11:15 A</b>  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (In years last birthday) <b>67</b> YRS.   |  |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hospital</b>                          |  | 9. COUNTY OF DEATH <b>Baltimore County</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED CLERK - U.S. GOVT VET. ADMIN.</b>               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>SCHOAL</b> Last <b>SCHOAL</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>BROOKS</b> Last <b>BROOKS</b>   |  | 13e. STREET AND NUMBER <b>1238 GLEN HAVEN RD.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>218-07-0761</b>  |  | 17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b><br><b>0112</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mo.</b>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>21 Mar 1969</b> to <b>22 Apr 1969</b> , that <del>we</del> (we) lost the deceased alive on <b>22 April 1969</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above; <del>we</del> (we) did (did not) view the body after death. <b>WJS</b>    |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>W Newcomer</b>   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>22 April 1969</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>   |  | 22e. ADDRESS <b>Mount Wilson, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4/25/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Dorsey Md.</b>                              |  |
| 24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>  |  | ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>  |  | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |
| DATE <b>APR 23 1969</b>  |  |  |  |  |  |  |  |

05184

CERTIFICATE OF DEATH

CLARENCE OSCAR SCHOOL

MALE WHITE

W 2

DATE OF BIRTH 12-28-1887

SCHOOL

12-28-1887

for the purpose of

with a view to

referred to

1/2/1900

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 4  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |  |   |  |  |                        |  |
|--|--|--|--------------------------|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |                          |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR               |  |
| JOSEPH EDWARD SCHOLTES   |  |  |                          |  |   | APRIL Month 25 Day 1969 Year   |  | 9:20 PM                |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR        |  |
| Male   |  | White  |                          | 3/19/96  |   | 73 YRS.  |  | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                        |  |
| PENNSYLVANIA   |  | U.S.A.   |                          |  |   | BALTIMORE  |  | Md.                    |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| FORT HOWARD  |  | VETERANS ADMINISTRATION HOSPITAL   |                          | Waiter   |   | SEA FOOD   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MARYLAND   |  |  |                          | BALTIMORE  |   |  |  | 642 E. Fort Avenue     |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last        |  |   |  |  |                        |  |
| PETER SCHOLTES   |  |  | ELIZABETH GABLE          |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT Address   |  |  |                        |  |
| YES WW I   |  |  | 186 01 01 44             |  | Clin. Records, VA Hospital, Fort Howard, Md.                        |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |  |   |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA   |  |  |                          |  |   |  |  |                        | DAYS   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |   |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |                          |  |   |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                          |  |   |  |  |                        |  |
| SEVERE ARTERIOSCLEROSIS  |  |  |                          |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |
|  |  |  |                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                        |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |                          |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |                        |  |
|  |  |  |                          |  |   |  |  |                        |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 1, 1969, to April 25, 1969, that (X) (we) last saw the deceased alive on April 25, 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death. |  |  |                          |  |   |  |  |                        |  |
| 22b. SIGNATURE   |  |  |                          |  | 22c. DATE SIGNED  |  |  |                        |  |
| Philip M. Ashman M.D.  |  |  |                          |  | 4/26/69   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |                          |  | 22e. ADDRESS  |  |  |                        |  |
| PHILIP M. ASHMAN, M.D.   |  |  |                          |  | VA HOSPITAL, FORT HOWARD, MARYLAND                                  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                        |  |
| Burial   |  | 4/29/69  |                          | New Cathedral Cemetery   |   | Baltimore, Maryland  |  |                        |  |
| 24. FUNERAL DIRECTOR   |  |  |                          | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |
| McCully Funeral Home   |  |  |                          | 130 E. Fort Avenue Baltimore, Maryland   |   | APR 29 1969  |  |                        |  |

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U.S. DEPT. OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |  |   |   |  |  |
|---|--|------------------------------|--|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |  |   |   |  |  |
| CERTIFICATE OF DEATH  |  |                              |  |  |  |   |   |  |  |
| 05186   |  |                              |  |  |  |   |   |  |  |
| 05178   |  |                              |  |  |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| CORDELIA  |  |                              | S. SCHULZ  |  |  | 04 Month 30 Day 69  |   | 11:12 PM   |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS  |  |
| FEMALE  |  | CAU                          |  | 1-12-90  |  | 79 YRS.   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |  |  |
| Md.   |  | U.S.A.                       |  |  |  | BALTIMORE   |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| TOWSON, MARYLAND  |  |                              | GTRR. BALTO. MED. CENTER   |  |  | HOMEMAKER   |   | OWN HOME   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                        |  |  |
| Md.   |  |                              | Baltimore  |  | Ruxton   |   | 2 WineSpring Garth                            |  |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |  |   |   |  |  |
| First Middle Last   |  |                              | First Middle Last  |  |  |   |   |  |  |
| John Stokes   |  |                              | Mary Ziegler   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address   |   |  |  |
| No  |  |                              |  |  |  | Mrs. Benjamin E. Beavin (Same)  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |  |   |   |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |  |   |   |  |  |
| IMMEDIATE CAUSE (a) VENTRICULAR TACHYARRHYTHMIA & PUL. EDEMA  |  |                              |  |  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |  |   |   |  |  |
| (b) ACUTE MYOCARDIAL INFARCTION   |  |                              |  |  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |  |   |   |  |  |
| (c) ARTERIOSCLEROTIC CARDIO VASULAR DISEASE   |  |                              |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |  |  |   |   |  |  |
| CH. C.H.F.  |  |                              |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19                              |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |  |  |
|   |  |                              |  |  |  | 10:30 PM 11:12 PM   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-30, 19 69, to 4-30, 19 69, that (I) (we) last saw the deceased alive on 11:12 PM 4-30 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |  |   |   |  |  |
| 22b. SIGNATURE  |  |                              | 22c. DATE SIGNED   |  |  |   |   |  |  |
| Dost Mohammad MD  |  |                              | 05-01-69   |  |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              | 22e. ADDRESS   |  |  |   |   |  |  |
| DOST MOHAMMAD MD  |  |                              | 6701 NORTH CHARLES STREET  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State) |  |  |
| Entombment  |  |                              | 5/3/69   |  | Lorraine Park  |   | Woodlawn, Balto. Co., Md.                     |  |  |
| 24. FUNERAL DIRECTOR  |  |                              | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |  |
| H.W. Jenkins & Sons Co.   |  |                              | DATE MAY 1 1969  |  |  | Charles Judge   |   |  |  |
| 4905 York Rd.   |  |                              |  |  |  |   |   |  |  |
| Balto. 12, Md.  |  |                              |  |  |  |   |   |  |  |

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Woodward & Lothrop



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## CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (Type or print) <b>aka (ROBERT HENRY Midl SCHULZ)</b> Last <b>HENRY SCHULZE</b>   |  |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>28</b> Day <b>1969</b>   |  |  |  | 2b. HOUR<br><b>7 P.M.</b>                                       |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 17, 1897</b>  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>200 Huron Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>commercial artist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>retired</b>  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Ctnsvll.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>200 Huron Road -21228</b>          |  |
| 14. FATHER'S NAME First <b>Herman</b> Middle <b>Schulze</b> Last <b>Schulze</b>  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Caroline</b> Middle <b>Rohrman</b> Last <b>Rohrman</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>yes</b> (If yes give dates of service) <b>WW I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-3846B</b>  |  | 17. INFORMANT Address<br><b>Mrs. Lillian E. Schulze 200 Huron Rd.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                            |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>68</b> , to <b>April</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/8</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Edgar P. Williamson M.D.</b> DEGREE   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4-30-69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Edgar P. Williamson</b>  |  |  |  | 22e. ADDRESS <b>5550 Balto. National Pike</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  | 23b. DATE <b>May 2, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                   |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>H. Sander &amp; Sons, Inc., Balto., Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print)  |  | First Middle Last  |  | 2a. DATE OF DEATH  |  | Month Day Year   |  | 2b. HOUR   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13. STREET AND NUMBER  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER   |  | 14. FATHER'S NAME First Middle Last  |  |
| 14. FATHER'S NAME First Middle Last  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  | PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |
| 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County   |  | State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

02182

STATE OF NEW YORK

|  |  |
|--|--|
| IN SENATE  |  |
| JANUARY 1, 1902                                  |  |
| REPORT   |  |
| OF THE   |  |
| COMMISSIONERS OF THE LAND OFFICE                 |  |
| IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE |  |
| MAY 1, 1899                                      |  |
| ALBANY:  |  |
| J. B. LEECH, PRINTER.                            |  |
| 1902   |  |

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05189

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05181

|  |  |   |  |  |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
|--|--|---|--|--|--|---|--|--|--|---|--|-----------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  | First   |  | Middle   |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED        |  | Month                                   |  | Day                         |  | Year  |  | 2b. HOUR |  |      |  |          |  |
| IDA  |  | ROSA  |  | SHETTLE  |  |   |  | April  |  | 27,                                     |  | 1969                        |  | 6:15  |  | AM       |  |      |  |          |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (In years<br>last birthday)                                  |  | IF UNDER 1 YEAR                                  |  | IF UNDER 24 HRS.                        |  | 2c. DATE PRONOUNCED DEAD    |  | Month |  | Day      |  | Year |  | 2d. HOUR |  |
| Female   |  | White   |  | Nov. 27, 1948  |  | 20 ?  |  | MONTHS   |  | DAYS                                    |  | HOURS                       |  | April |  | 27,      |  | 1969 |  | 6:15     |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH  |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| Maryland   |  | USA   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | Baltimore   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| Parkville  |  | Putty Hill & Fern Avenue  |  | Machine Operator   |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                           |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| Maryland   |  | Balto.  |  | Parkville  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2517 Glenco Rd.                                  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 14. FATHER'S NAME  |  | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME                         |  | First                                   |  | Middle                      |  | Last  |  |          |  |      |  |          |  |
| George E. Orwig  |  |   |  |  |  |   |  | Elizabeth R. McLew                               |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| No   |  | 217-50-4889   |  | Kenneth G. Shettle   |  | (Same)  |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-cerebral Injuries</u><br>8161<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  | 20. AUTOPSY?   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>5:45 PM 4-27- 1969   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Passenger, <del>xx</del> auto struck utility pole |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Street   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Putty Hill & Fern Ave. Parkville Balto. M.D.                         |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| ACTUAL<br>SIGNATURE  |  | Ronald N. Kornblum, M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>      |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br>4/27/69 |  |       |  |          |  |      |  |          |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/30/69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Maryland |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. 5305 Harford Road 21214   |  | 25a. REC'D BY REGISTRAR<br>DA APR 29 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge  |  |   |  |  |  |   |  |                             |  |       |  |          |  |      |  |          |  |

05189

Nov. 27, 1961

27-11-61

Received from

John H. Johnson

11/27/61

11/27/61

11/27/61

11/27/61

11/27/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |
| 05190  |  |  |  |   |  |   |  |  |  |
| 05182  |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Erman A Shoemaker</b>   |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>23</b> Year <b>69</b>                     |   |  | 2b. HOUR<br><b>1:45 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>JAN. 21, 1887</b>  |  | 6. AGE (in years last birthday)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Chapel Hill Conv.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FARMER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FARM</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Carroll</b>  |  | 13c. CITY OR TOWN<br><b>WESTMINSTER</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>GREEN STREET</b>                          |  |
| 14. FATHER'S NAME First Middle Last<br><b>DAVID M. SHOEMAKER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY - BLACK</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>   |  | 17. INFORMANT Address<br><b>MRS. NORMAN HULL WESTMINSTER, Md.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Crowning Thrombosis, A.S.H.D.</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>C.A.S. severe thrombosis and</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Brain Syndrome, Cystitis</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>to 4-23-69</b>      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>TURP prostate</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>4-23, 1969</b> , that (I) (we) last saw the deceased alive on <b>4-23, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Howard E. Hall MD</b> DEGREE  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4-23-69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Howard E. Hall, M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>College Ave. Sykesville, Maryland</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-26-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springfield Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Sykesville, Md.</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>   |  |  |  | ADDRESS<br><b>Sykesville, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 29 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Michael J. Young</b>                  |  |

DEFG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |  |  |  |   |  |
|---|--|--|---|---|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |  |  |  |   |  |
| 05191   |  |  |   |   | 05183   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |   |  |
| First Middle Last<br><b>WILLIAM</b> <b>SHRIVER</b>  |  |  |   |   | Month Day Year<br><b>APRIL 30, 1969</b>   |  |  | <b>8:10 PM</b>   |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br><b>MARCH 10, 1897</b>   |   | 6. AGE (In years lost birthday)<br><b>72</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  | Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOSPITAL VETERANS ADMINISTRATION</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FARMER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>DORCHESTER</b>  |   | 13c. CITY OR TOWN<br><b>CAMBRIDGE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>R.F.D. # 3</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>HENRY A SHRIVER</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ANNA COMSTOCK</b>  |   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216 56 1278</b>  |   | 17. INFORMANT Address<br><b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MILIARY TUBERCULOSIS LUNGS, BILATERAL</b><br><b>0114</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c)<br>stating the underlying cause lost.<br><b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RHEUMATOID ARTHRITIS, MARKED</b>  |  |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that <del>XXXX</del> (we) attended the deceased from <b>4/26/69</b> , 19__, to <b>4/30/69</b> , 19__, that <del>XX</del> (we) last saw the deceased alive on <b>4/30/69</b> , 19__, and that in <del>XXXX</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>X</del> (we) (did) <del>(did not)</del> view the body after death.  |  |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Erhard J. Bunyor M.D.</b> DEGREE  |  |  |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/30/69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M. D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MD</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>May 5, 1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL CEMETERY</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD</b>                                    |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>E.B. Fleming</b> ADDRESS <b>Burnie, Md</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAY 5 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |
| Singleton Funeral Home, 2nd ave SW, Glen  |  |  |   |   | DATE  |  |  |  |   |  |

107101

STATEMENT OF DEATH

NAME: WILLIAM  
DATE OF BIRTH: 1910  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: 1970  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MARRIED: [illegible]  
SPOUSE: [illegible]  
CHILDREN: [illegible]  
SIBLINGS: [illegible]  
PARENTS: [illegible]  
GRANDPARENTS: [illegible]  
BROTHERS: [illegible]  
SISTERS: [illegible]  
Nephews: [illegible]  
Nieces: [illegible]  
Aunts: [illegible]  
Uncles: [illegible]  
Cousins: [illegible]  
In-laws: [illegible]  
Out-laws: [illegible]  
Other relatives: [illegible]  
Other persons: [illegible]  
Other: [illegible]

INTERVIEWED PERSONS, LISTED

INTERVIEWED PERSONS, LISTED

INTERVIEWED PERSONS, LISTED

107101

107101

107101

107101

REMARKS: [illegible]

BALTIMORE, MD

DATE OF DEATH: 1970

107101

107101

MAY

1970

107101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05192  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05184   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |
| MYRTLE F. SHROM  |  |  |  |  |  |  |  |  |  | April Month 6, 1969 Year   |  |  |  |  |  |  |  |  |  | M   |  |  |  |  |  |  |  |  |  |
| 3. SEX Female  |  |  |  |  | 4. RACE White  |  |  |  |  | 5. DATE OF BIRTH April 1, 1883   |  |  |  |  | 6. AGE (In years last birthday) 86 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS   |  |  |  |  | IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Penna.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH Baltimore Md.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Arbutus  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1030 Elm Road |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland   |  |  |  |  | 13b. COUNTY Baltimore  |  |  |  |  | 13c. CITY OR TOWN Arbutus  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 13e. STREET AND NUMBER 1030 Elm Road  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last Unknown  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No   |  |  |  |  | (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. 190-09-2362   |  |  |  |  | 17. INFORMANT Address Mrs. Robert B. Grayson, 1030 Elm Road 21227  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4124 Cardiac Vascular Disease  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1967, 19 to 4/6, 1969, that (I) (we) last saw the deceased alive on 4/6 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Dr. James N. Frederick  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED 4/7/69   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. James N. Frederick  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 1311 Francis Avenue, Balto., Md. 21227  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REVENUE (Specify) BURIAL   |  |  |  |  |  |  |  |  |  | 23b. DATE 4-9-1969   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery  |  |  |  |  |   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Dorsey, Howard County, Md. |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE APR 9 1969  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge  |  |  |  |  |  |  |  |  |  |



02100

YITIN 5. JERUSALEM 10, 1950

To: Mr. J. H. ...

From: Mr. J. H. ...

At: Mr. J. H. ...

Subject: Mr. J. H. ...

Reference: Mr. J. H. ...

Enclosure: Mr. J. H. ...

*Handwritten signature*

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

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Mr. J. H. ...

Mr. J. H. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|---|--|---|--|
| 05193  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  | 05185   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Lewis NMI Siperko</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 30 69</b>    |   | 2b. HOUR<br><b>5:45 PM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>12/2/97</b>  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.                               | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                            |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Wilkes Barre PA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Cnty. Gen.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Merchant</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Univer sal Machine Co.</b>              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Balto.</b>   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET AND NUMBER<br><b>Rte. 2 Deer Park Rd.</b>        |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Matthew Siperko</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary ?</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>189-01-7029</b>  |  | 17. INFORMANT Address<br><b>Linnea R. Siperko Deer Park Rd. Owings Mills</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive and Massive Pulmonary Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Kaposi's Sarcoma</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Dr. C. Caverio</i>  |  |   |  | 22c. DATE SIGNED<br><b>4.30.69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. C. Caverio</b>  |  |   |  | 22e. ADDRESS<br><b>8629 Liberty Rd., Randallstown, Md.</b>                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 3, 69</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b> |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie Md. Annapundal</b> |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers</b>  |  |   | ADDRESS<br><b>8728 Liberty Rd. Randallstown</b>              |   | 25a. REC'D BY REGISTRAR<br><b>MAY 5 1969</b>                                       |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05194

## CERTIFICATE OF DEATH

Reg. Dist. No.

05186

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                  |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Pikesville</b>  |                               | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>3 Sudbrook Crt., Pikesville, Md.</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Miriam Slesinger</b> First Middle Last <b>Bechhofer Slesinger</b>   |                               | 4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1969</b>  |                                       |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 27, 1885</b> |
| 9. AGE (In years last birthday) <b>83</b> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Slesinger</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                       |
| 13. FATHER'S NAME<br><b>Alexander Bechhofer</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Straus</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>  |                               | 16. SOCIAL SECURITY NO. <b>218-01-0055</b>   |                                       |
| 17. INFORMANT <b>Mrs. Alice S. Eigenbrun</b>   |                               | Address <b>Maryland</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br><b>436.9</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>years</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes with gangrene of left foot</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>January, 1969</b> to <b>7/5</b> , 1969, that I last saw the deceased alive on <b>4/1</b> , 1969, and that death occurred at <b>4:20 P</b> M, from the causes and on the date stated above.  |                               |  |                                       |
| ACTUAL SIGNATURE <b>Louis H. Schaffer</b>  |                               | ADDRESS (Street, city or town, state) <b>272 W Cold Spring Lane, Balto, Md</b>   |                                       |
| PHYSICIAN'S NAME (Type) <b>LOUIS H. SCHAFER, M.D.</b>  |                               | DATE SIGNED <b>4/7/69</b>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                               | 22b. DATE THEREOF<br><b>April 9, 1969</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>   |                               | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Frank H. Newell</b>   |                               | 24a. REC'D BY REGISTRAR<br><b>APR 9 1969</b>   |                                       |
| ADDRESS<br><b>Pikesville 8, Md.</b>  |                               | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                       |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05195

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05187

|   |                         |   |  |   |   |  |  |  |  |
|---|-------------------------|---|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Susan E. Small</b>   |                         |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Apr.</b> Day <b>16</b> Year <b>1969</b> |   |   | 2b. HOUR <b>10 p.m.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>4-13-1877</b>  | 6. AGE (In years last birthday)<br><b>92</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Apr.</b> Day <b>16</b> Year <b>1969</b>     |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Chapel Hill Nursing Home</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>at home</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                         |   | 13b. COUNTY <b>Balto.</b>  |   | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME First <b>Charles</b> Middle <b>Emich</b> Last <b>Fulton</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First <b>Fulton</b> Middle <b>Fulton</b> Last <b>Fulton</b>                         |   |   | 13e. STREET AND NUMBER<br><b>5511 Gwynn Oak Avenue 7</b>                         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                         |   | 16b. SOCIAL SECURITY NO. <b>No</b>   |   |   | 17. INFORMANT ADDRESS<br><b>William R. Small-R.D.1-Holtwood, Pa. 17532</b>       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4409</b><br>(b) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Arteriosclerosis</b>                                       |                         |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 da.</b><br><b>2 wks.</b><br><b>5 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Fracture of rt. hip- Decubitus ulcers, extensive.</b>  |                         |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>Mar. 9, 1969</b>   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fractured hip</b>                                     |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>5:15 P.M. Mar. 8 1969</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>slipped off comode in room and fractured hip.</b>                     |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Chapel Hill Nurs. Home</b>   |  | 21f. LOCATION Street or R.F.D. No. <b>Randallstown</b> City or Town <b>Balto.</b> County <b>Md.</b>   |   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>4-19-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Armacost Funeral Chapel-4600 Liberty Hts.</b>  |                         |   | ADDRESS<br><b>Armacost Funeral Chapel-4600 Liberty Hts.</b>  |   |   | 25a. REC'D BY REGISTRAR<br><b>APR 22 1969</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

*D.D. Caples*

**D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md.**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED

**4-18-69**

78130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 05196   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05188  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year   |  | 2b. HOUR                                     |  |
| MARY A. Smith   |  |  |  |  |  | 4 12 69  |  | 950 M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                              |  |
| Female  |  | White  |  | 5-14-1880  |  | 88 YRS.  |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Maryland  |  | U.S.   |  |  |  | Baltimore Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Garrison, Md.   |  | Stoxleigh Nurs. Hm.  |  | homemaker  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.   |  | Balto.   |  |  |  |  |  | 624 Dunkirk Road                             |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |
| Smith, A. George  |  | Catherine Moylan   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |  |  |
| no  |  | 220-30-2638  |  | Nellie M. Patterson 606 B Walker Ave. #21212   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction  |  |  |  |  |  |  |  | hours  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis  |  |  |  |  |  |  |  | years  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 2, 1967, to April 12, 1969, that (I) (we) last saw the deceased alive on April 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |  |  |
| David J. Miller   |  |  |  |  |  | April 12-69  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| David J. Miller   |  | 9115 Reisterstown Rd Owings Mills Md   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 4/15/69  |  | Cathedral Cemetery   |  | Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Mitchell-Wiedefeld Home 6500 York Rd. Balto Md 21212  |  |  |  | APR 18 1969  |  | Charles Judge  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |   |  |   |  |   |                                   |                               |  |
|---|--|---|--|---|--|---|--|---|-----------------------------------|-------------------------------|--|
| 05197   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                         |  |   |  | 05189   |  |   |                                   |                               |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>WILLIAM TAYLOR SMITH  |  |   |  |   |  | 2a. DATE OF DEATH<br>April Month 7, 1969 Year   |  |   |                                   | 2b. HOUR<br>M                 |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>11-17-1913  |  | 6. AGE (In years last birthday)<br>55 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                        |                                   | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |                                   |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Edmondson Heights  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1147 Granville Road |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Banker |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Edmondson Heights  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET AND NUMBER<br>1147 Granville Road         |                                   |                               |  |
| 14. FATHER'S NAME First Middle Last<br>Joseph Roane Smith, Jr.  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ethel R. Taylor   |  |   |  |   |                                   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW 11   |  | 17. INFORMANT<br>Mrs. Helen K. Smith, 1147 Granville Road   |  | Address   |  |   |                                   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |   |  |   |  |   |  |   |                                   |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Previous myocardial infarction</u>   |  |   |  |   |  |   |  |   |                                   |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                              |  |   |                                   |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                   |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |                                   |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>4/7</u> , 19 <u>69</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>June</u> 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>not</u> ) view the body after death.   |  |   |  |   |  |   |  |   |                                   |                               |  |
| 22b. SIGNATURE<br><u>James Nolan</u>  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>4/8/69</u>   |  |   |                                   |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. James Nolan   |  |   |  | 22e. ADDRESS<br>1 Mallow Hill Road, Balto., Md.   |  |   |  |   |                                   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-10-1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Pikesville, Maryland                             |  |   |                                   |                               |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>APR 9 1969<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE<br><u>William J. Jones</u> |                                   |                               |  |

05197



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Person in general of before

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 05198   |  | CERTIFICATE OF DEATH  |  |   |  |   |  | 05190  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>WARREN A. SpILMAN   |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br>April 6, 1969  |   |  | 2b. HOUR<br>10 P.M.  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>11-30-1903  |  | 6. AGE (In years last birthday)<br>65 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTO.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BANDALLSTOWN   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>BALTO Co. Gen. Hosp |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CYP Telephone |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br>6100 WINDSOR Mill. Rd            |  |
| 14. FATHER'S NAME First Middle Last<br>Robert E. SpILMAN  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Julie Provost   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown<br>No   |  | 16b. SOCIAL SECURITY NO.<br>577-01-9143   |  | 17. INFORMANT Address<br>HAZEL R. SpILMAN - Same  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hours    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17, 1944, to 4/6, 1969, that (I) (we) last saw the deceased alive on 3/31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.                                  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert A. Reiter, M.D.  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/7/69                                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Robert A. Reiter, M.D.  |  |   |  | 22e. ADDRESS<br>606 Edmondson Ave, 21228  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-10-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CEMETERY   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>ARMACAST FUNERAL CHAPEL   |  |   |  | ADDRESS<br>4600 Lib. Hgts Ave   |  | 25a. RECD BY REGISTRAR<br>APR 8 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...              |  |

I, the undersigned, being a duly qualified medical officer of health for the City of New York, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of  
 the person named therein, as the same appears from the files of the Department of Health, City of New York.  
 In testimony whereof, I have hereunto set my hand and the seal of the Department of Health, at New York,  
 this 10th day of May, 1908.

Robert A. Thompson, M.D.,  
 Medical Officer of Health, City of New York.

Signed and attested at New York, this 10th day of May, 1908.  
 J. J. [illegible]  
 [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05199

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05191

## CERTIFICATE OF DEATH

|  |      |  |         |   |   |   |  |  |      |
|--|------|--|---------|---|---|---|--|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |      | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |   | P. HOUR<br>p. 11:25 M  |  |      |
| Luther   |      | Stallings  |         |   | April 4, 1969   |   |  |  |      |
| 3. SEX   | male |  | 4. RACE | white   |   | 5. DATE OF BIRTH  | 1905   |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |      | 7b. CITIZEN OF WHAT COUNTRY?   |         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |      |
| Md.  |      | U. S.  |         | 9. COUNTY OF DEATH  |   | 63 YRS.   |  | Baltimore Md                                 |      |
| 10. CITY OR TOWN OF DEATH  |      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |      |
| Catonsville  |      | SPRING GROVE STATE HOSP.   |         | laborer   |   |   |  |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |      | 13b. COUNTY  |         | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |      |
| Md.  |      | Calvert  |         | St. Leonard   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | none   |      |
| 14. FATHER'S NAME  |      | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |   | First  | Middle                                       | Last |
| William  |      |  |         |   | Katie   |   |  |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |      | (If yes give war or dates of service)  |         | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  | Address                                      |      |
|  |      |  |         |   |   | Records: SPRING GROVE STATE HOSPITAL  |  |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Recent bronchopneumonia.<br>(c)    |      |  |         |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
|  |      |  |         |   |   |   |  |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |      |  |         |   |   |   |  |  |      |
| 19a. DATE OF OPERATION   |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |         |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |  |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |   |  |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19, 1950, to April 4, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |      |  |         |   |   |   |  |  |      |
| 22b. SIGNATURE   |      | 22c. DATE SIGNED   |         |   | 22d. PHYSICIAN'S NAME (Type)  |   | 22e. ADDRESS   |  |      |
| Rafael H. Marin  |      | 4-7-69   |         |   | Rafael H. Marin, M.D.   |   | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228             |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |      | 23b. DATE  |         | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |      |
| Buried April 11 1969   |      | April 11 1969  |         | New Cathedral   |   | Old Church Road Baltimore Md  |  |  |      |
| 24. FUNERAL DIRECTOR   |      | ADDRESS  |         |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |      |
| Krause Funeral Home  |      | 1216 S Charles St  |         |   | APR 14 1969   |   | Charles Judge  |  |      |

05150

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

HEIGHT

WEIGHT

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

*[Faint, illegible text, likely a signature or official statement]*

*[Faint, illegible text, likely a signature or official statement]*

*[Faint, illegible text, likely a signature or official statement]*

*[Faint, illegible text, likely a signature or official statement]*

*[Faint, illegible text, likely a signature or official statement]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| 05200   |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 05192   |   |
| Item 8 Film 413 5/29/69 kk  |   |  |  |   |   |
| 1. DECEASED-NAME<br>(Type or print) <b>Emmet E. Stevens</b>   |   |  | 2a. DATE OF DEATH<br><b>April 21 1969</b>  |   | 2b. HOUR<br><b>M</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br><b>3-23-1910</b>   |  | 6. AGE (In years<br>last birthday)<br><b>59</b> YRS.                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.        |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Carpenter</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Kingsville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>629 New Cut Road</b>                               |   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Allie B. Stevens</b>   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Annie M. Bell</b>   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>WWII</b>  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>216-10-0294</b>                       | 17. INFORMANT<br>Address<br><b>Mrs. Michael Raab 3102 Batavia Ave. 21214</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion -2 1/2 hrs.</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if only, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/30/61</b> , 19____, to <b>4/21/69</b> , 19____, that (I) (we) last<br>saw the deceased alive on <b>4/21/69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Theodore E. Evans M.D.</b>   |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                                  |  | 22c. DATE SIGNED<br><b>4/22/69</b>  |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Theodore E. Evans, M.D.</b>   |   | 22e. ADDRESS<br><b>Perry Hall Medical Center 9660 Belair Rd</b>  |  |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  | 23b. DATE<br><b>4-24-69</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Lawn Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bowling Green, Virginia</b> |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 24 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |   |

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Letter to the Editor, October 1968

Theodore R. Brown, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| 05201   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 05193   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | 2a. DATE OF DEATH  |   |  |  |
| First Middle Last<br><b>CHARLES ALBERT STEWART</b>  |  |  | Month Day Year<br><b>4 30 69</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>2/20/98</b>   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maine</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Vet. Adm. Hosp. Ft. Howard, Md.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Maint. Man</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Virginia</b>  |  |  | 13b. COUNTY<br><b>Occamack</b>   |   | 13c. CITY OR TOWN<br><b>Onancock</b>   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William Stewart</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Jeanette</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 18 33 82</b>  |   | 17. INFORMANT<br>Address<br><b>Clin. Records, Va Hosp. Ft. Howard, Md.</b>                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>492x</b><br>(b) <b>OBSTRUCTIVE EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>3/22/69</b> , 19____, to <b>4/30/69</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/30/69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                                 |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>John D. Talbert, M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/30/69</b>   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>VAH FT HOWARD, MARYLAND</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/3/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Lawn Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Onancock accomack Va</b> |
| 24. FUNERAL DIRECTOR<br><b>Severda Park</b><br><b>Robert S. Benavides MD.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>ADDRESS<br><b>CARLISLE WILLIAMS FUNERAL HOME</b><br><b>ONANCOCK, VIRGINIA</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                           |

AGE: 0      CO      OE

RECEIVED      REP. JOHN      B. B. BRIDGES      51      070      JAN. 30

[illegible]

VAN ET HOWARD, MARILYN D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

| 05202   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05194  |  |                  |  |
|---|--|--|--|--|--|--|--|--|--|------------------|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  | 20. DATE OF DEATH  |  |  |  | 2b. HOUR                                     |  |                  |  |
| LOUISE CAROLINE LIZETTE STISSEL   |  |  |  | April 8 1969   |  |  |  | 4:30 PM                                      |  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS. |  |
| Female  |  | White  |  | March 31, 1879   |  | 90 YRS.  |  | MONTHS                                       |  | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                  |  |
| Balto., Md.   |  | USA  |  |  |  | Baltimore County   |  |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |                  |  |
| Towson  |  | Dulaney-Towson Nurs. Home  |  | NONE   |  |  |  |  |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived/admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER                       |  |                  |  |
| Maryland  |  |  |  | Balto. City  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1823 East 31st. Street                       |  |                  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                  |  |
| Wilhelm   |  | Hundertmark  |  | Julia  |  | Grohne   |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |                  |  |
| NO  |  | 220-44-8228  |  | Carl F. Stissel,   |  | 2445 Pickwick Rd., Balto.  |  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |                  |  |
| 4123 IMMEDIATE CAUSE (a) Pulmonary edema.   |  |  |  |  |  |  |  | 1 1/2 hr.                                    |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |                  |  |
| (b) Arteriosclerotic heart disease  |  |  |  |  |  |  |  | 10 yrs.                                      |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |                  |  |
| (c)   |  |  |  |  |  |  |  |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |  |  |  |  |  |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town                                 |  | County State     |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Apr. 1968 to 4/8, 1969, that (I) (we) lost saw the deceased alive on Sept 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |                  |  |
| Norman R. Freeman   |  | 4/9/69   |  |  |  |  |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |                  |  |
| Norman R. Freeman   |  | 11 W. 29th St.   |  |  |  |  |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |                  |  |
| BURIAL  |  | Apr. 10, 69  |  | PARKWOOD   |  | Taylor Av., Parkville, Balto.  |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                  |  |
| STEWART & MOWEN CO.   |  | 108 W. North Av., City 1   |  | APR 11 1969  |  | f. Charles Jones   |  |  |  |                  |  |

05805

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C.

March 21, 1939

Mr. J. H. ...

Dear Sir:

I have your letter of March 14, 1939, regarding the ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 3/4  
30M REV. 1/68

05203

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05195

|  |  |   |   |   |                     |   |  |   |                    |   |  |
|--|--|---|---|---|---------------------|---|--|---|--------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br>MILTON   | Middle<br>VICTOR  | Lost<br>STRASBURGER | 2a. DATE OF DEATH<br>Month Day Year<br>APRIL 25, 1969   |  |   | 2b. HOUR<br>7 A.M. |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH  |                     | 6. AGE (In years<br>last birthday)<br>96 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                    | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>WESTMINSTER, MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |   |                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>CHAPEL HILL NURSING HOME |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>SALESMAN  |                     | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>INSURANCE   |  |   |                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>3301 DORITHAN ROAD                            |                    |   |  |
| 14. FATHER'S NAME<br>First Middle Lost<br>VICTOR C. STRASBURGER  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br>SALLIE STEIN |   |                     |   |  |   |                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No, or unknown)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-22-6003   |   | 17. INFORMANT<br>Address<br>MR. LEROY STRASBURGER, 3800 MENLO DRIVE   |                     |   |  |   |                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Squamous cell C.A. of mouth<br>1459 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases to mouth and Neck<br>DUE TO, OR AS A CONSEQUENCE OF mandible and lymphatics<br>(c) |  |   |   |   |                     |   |  |   |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |                     |   |  |   |                    |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |                     |   |  |   |                    |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |                     |   |  |   |                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-5-1969, to 4-25-1969, that (I) (we) last saw the deceased alive on 4-25-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                     |   |  |   |                    |   |  |
| 22b. SIGNATURE<br>Cesar Valle Cavero   |  |   |   |   |                     | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-25-69   |                    |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>CESAR VALLE CAVERO  |  |   |   |   |                     | 22e. ADDRESS<br>8629 LIBERTY ROAD   |  |   |                    |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-27-69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP   |                     | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND  |  |   |                    |   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD   |  |   |   |   |                     | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 30 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |                    |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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05204

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05196

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>HENRY</b> <b>H.</b> <b>SULLIVAN</b>   |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <b>69</b> <b>11</b> <b>18</b> <b>M</b>  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>Aug. 3, 1910</b>  | 6. AGE (In years last birthday)<br><b>58</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6905 Dunmanway</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Blocker, Wire Mill</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Dundalk</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |
| 14. FATHER'S NAME<br><b>James S. Sullivan</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Lulu Turner</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>223-20-4749</b>   |   | 17. INFORMANT<br><b>Thomas C. Sullivan</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HEVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. <input type="checkbox"/> City or Town <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/>   |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Theodore C. Patterson</b><br>EXAMINER'S NAME (Type) <b>Theodore C. Patterson, M.D.</b>  |  |  | 22b. DATE SIGNED<br><b>4/11/69</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) <b>3427 Dundalk Ave.</b> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Apr. 12, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorsey, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home, Dundalk, Md.</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 14 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

02504

MEMORANDUM FOR THE CHIEF OF BUREAU

OFFICE OF THE CHIEF OF BUREAU

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FOR STATE  
HEALTH DEPT.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |                         |  |   |  |  |   |  |  |   |  |
|---|-------------------------|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                         |  |   |  |  |   |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |   |  |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>Stanley</b>  |                         |  | First Middle Last <b>Szczzech</b>   |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>1969</b> |  | 2b. HOUR <b>5:20</b>                         |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Aug. 12, 1906</b>                                     | 6. AGE (In years last birthday)<br><b>62</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD<br><b>April 28 1969</b>  |  | 2d. HOUR <b>7:30</b>                         |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Box 199 Route 10</b>                       |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farm Work</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>Maryland</b>  |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Ft. Howard</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Box 199 Route 10</b> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Andrew Szczechowiak</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Frances Teclaw</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)                                  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-07-9296</b>  |                         |  | 17. INFORMANT<br><b>Brother Joseph Szczzech</b>   |  |  | ADDRESS<br><b>Ft. Howard, Md. Box 199 Route #10</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b><br><b>4/24</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                         |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                         |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> <b>19</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                     |   |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |   |  |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                         |  | EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>   |  |  | M.D. <b>M. D.</b>   |  | 22b. DATE SIGNED <b>4/28/69</b>              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>4/29/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>             |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |  |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 30 1969</b>                                    |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |

05205

FOR THE  
UNITED STATES

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05206

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05198

|   |                  |  |   |  |   |  |   |  |                                 |  |  |
|---|------------------|--|---|--|---|--|---|--|---------------------------------|--|--|
| 1. DECEASED-NAME (Type or Print) <b>ANNIE MARIE TAYLOR</b>  |                  |  |   |  |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> APR 21 1969 |   |  | 2b. HOUR 5 A.M.                 |  |  |
| 3. SEX <b>F</b>   | 4. RACE <b>C</b> | 5. DATE OF BIRTH <b>7-4-90</b>   | 6. AGE (in years last birthday) <b>78</b> YRS.  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD Month <b>APR</b> Day <b>21</b> Year <b>1969</b>         |                                 | 2d. HOUR <b>8:50 AM</b>                      |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTIMORE</b>  |   |  |                                 |  |  |
| 10. CITY OR TOWN OF DEATH <b>COVANS</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>437 SCHWARTZ AVE</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>                            |                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>   |                  | 13b. COUNTY <b>Balto.</b>  |   | 13c. CITY OR TOWN <b>Covans</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 13e. STREET AND NUMBER <b>437 Schwartz ave</b>                                   |                                 |  |  |
| 14. FATHER'S NAME First <b>James</b> Middle <b>Batty</b> Last <b>Mitchner</b>   |                  |  | 15. MOTHER'S MAIDEN NAME First <b>Laura</b> Middle <b>Mitchner</b> Last <b>Mitchner</b> |  |   |  |   |  |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                  |  | 16b. SOCIAL SECURITY NO. <b>815-12-0426</b>   |  |   | 17. INFORMANT ADDRESS <b>Robert Taylor-4917 Midwood ave. Balto. Md.</b>                                |   |  |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b><br>1830<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC CARCINOMA OF OVARY</b><br>DUE TO, OR AS A CONSEQUENCE OF, <b>10 YRS.</b><br>(c) <b>10 YRS.</b>   |                  |  |   |  |   |  |   |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                  |  |   |  |   |  |   |  |                                 |  |  |
| 19a. DATE OF OPERATION  |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>                           |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |   |  |                                 |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)            |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                 |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |  |   |  |   |  |                                 |  |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>  |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED <b>4-21-69</b> |  |  |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |                  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |  |   | ADDRESS (Street, city, town, or county) <b>1101 N. E. St. Balto. Md.</b>                               |   |  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                  | 23b. DATE <b>4/25/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest</b>  |   |  | 23d. LOCATION (City or Town) (County) (State) <b>Towson, Balto. Co. Md.</b> |  |                                 |  |  |
| 24. FUNERAL DIRECTOR <b>Wm. J. Chaturan</b> ADDRESS <b>7-1701 Mt. Calhoun St. Balto. Md.</b>  |                  |  |   |  |   | 25a. REC'D BY REGISTRAR <b>APR 23 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                  |                                 |  |  |

05202

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05207

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05199

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>GEORGE H. THOMAS, SR.</b>  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>17</b> Year <b>1969</b> |  |  | 2b. HOUR <b>8:00</b> M   |  |  |
| 3. SEX <b>Male</b>  |  |  | 4. RACE <b>White</b>  |  |  | 5. DATE OF BIRTH <b>Aug. 191887</b>  |  |  |
| 6. AGE (In years last birthday) <b>81</b> YRS   |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. COUNTY OF DEATH <b>Baltimore</b>   |  |  | 10. CITY OR TOWN OF DEATH <b>Essex 21221</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>373 Walnut Grove Road</b>  |  |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Steel Worker</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>   |  |  | 13a. STREET AND NUMBER <b>373 Walnut Grove Road</b>  |  |  |
| 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN <b>Essex 21221</b>  |  |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |
| 14. FATHER'S NAME <b>Charles W. Thomas</b>  |  |  | 15. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Dingle</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |  |
| 16b. SOCIAL SECURITY NO. <b>215 01 7726</b>   |  |  | 17. INFORMANT <b>Catherin Kellner</b>   |  |  | 17. ADDRESS <b>Same</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1621</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>   |  |  | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED <b>4/17/69</b>  |  |  |
| EXAMINER'S NAME (Type) <b>M. B. Davis, M.D. 6800 Mornington Road Dundalk, Md. 21222</b>   |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  | 23b. DATE <b>4/21/69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>  |  |  |
| 23d. LOCATION (City or Town) <b>Baltimore, Maryland</b>   |  |  | 23e. LOCATION (City or Town) (County) (State)   |  |  | 23f. LOCATION (City or Town) (County) (State)  |  |  |
| 24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home</b>   |  |  | 24a. ADDRESS <b>1407 Eastern Ave.</b>   |  |  | 25a. REC'D BY REGISTRAR <b>APR 21 1969</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  | 25c. REGISTRAR'S SIGNATURE  |  |  | 25d. REGISTRAR'S SIGNATURE   |  |  |



03207

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |   |  |  |   |
|--|--|---|---|---|--|--|---|
| 05208  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |   |   |  | 05200  |   |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year  |   |
| Harry Lester Thompson  |  |   |   |   |  | April 18 1969  |   |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |   |
| Male   |  | White   |   | 4/24/03   |  | 65 YRS.  |   |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |
| Balto., Md.  |  | U. S. A.  |   |   |  | Baltimore County Md.   |   |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |
| Catonsville  |  |   | Spring Grove State Hosp.  |   |  | Ret. Salesman  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |   | 13b. CITY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland   |  |   | Baltimore   |   | Catonsville  |  | 13e. STREET AND NUMBER  |
| 14. FATHER'S NAME  |  |   | First   | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |   |
| Harry Thompson   |  |   |   |   |  | Mary Sue Anderson Thompson   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |  |   |
| Yes  |  |   | 217-05-0136   |   | Records-Spring Grove State Hospital  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized arteriosclerosis and diabetes</u> |  |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If injury, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
|  |  |   |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/21/67</u> , 19 <u>67</u> , to <u>4/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.   |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Evelio A. Felipe MD</u>   |  |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>4-18-69</u>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>EVELIO A. FELIPE MD</u>   |  |   |   | 22e. ADDRESS<br><u>Spring Grove State Hospital<br/>Baltimore, Maryland 21228</u>  |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |
| Burial   |  | 4-21-69   |   | Baltimore National  |  | Balto. City Baltimore Md.  |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Howard H. Hubbard 4107 Wilkens Ave. 21229</u>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><u>APR 21 1969</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

02208

STATE OF TEXAS

COUNTY OF DALLAS

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April 11, 1900

John W. ...

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05209

05201

|   |                         |   |  |   |  |   |  |   |  |  |  |
|---|-------------------------|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>SHERRY</b>  |  | Middle<br><b>GENENE</b>   |  | Last<br><b>TOTH</b>   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year <b>April 23, 1969</b> |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>11/30/1968</b>   |  | 6. AGE (In years<br>last birthday)<br><b>5</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year <b>April 23, 1969</b> |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>MD. Balt. city</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>948 Baynor Road</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>  |                         | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>948 Baynor Road</b>  |  |  |  |
| 14. FATHER'S NAME<br><b>ISHMAEL G. TOTH</b>   |                         | First Middle Last   |  | 15. MOTHER'S MAIDEN NAME<br><b>BETTY SIERAK</b>   |  | First Middle Last   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>—</b>  |  | 17. INFORMANT<br><b>MR. ISHMAEL G. TOTH</b>   |  | ADDRESS<br><b>948 BAYNOR RD</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>036.1</b> IMMEDIATE CAUSE (a) <b>Meningococcemia (Waterhouse-Fredrichsen Syndrome)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                         |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |   |  |   |  |   |  |  |  |
| ACTUAL<br>SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>  |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED<br><b>4/23/69</b>  |  |  |  |
| EXAMINER'S<br>NAME (Type)   |                         | ADDRESS<br><b>2525 FLEET ST.</b>  |  | 23a. REC'D BY REGISTRAR<br><b>APR 29 1969</b>   |  | 23b. REGISTRAR'S SIGNATURE<br><b>William J. Yager</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>4/26/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MD.</b>                           |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>RAYMOND L. KACZOROWSKI</b>   |                         | ADDRESS<br><b>2525 FLEET ST.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>APR 29 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Yager</b>   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05210

CERTIFICATE OF DEATH

05202

|  |  |   |   |   |  |   |   |   |  |
|--|--|---|---|---|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>M. Louise Tracey</b>  |  |   | 2a. DATE OF DEATH<br><b>April</b> Month <b>7</b> Day <b>1969</b>                      |   |  | 2b. HOUR<br><b>9:40 A.M.</b>  |   |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br><b>July 7, 1892</b>   |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Freeland</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Zion Rd.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Seamstress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing Factory</b>                                    |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Freeland</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Mt. Zion Rd.</b>                                   |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Still</b> Last <b>Still</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Sophia</b> Middle <b>Wirtz</b> Last <b>Wirtz</b> |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>188-10-7637</b>  |   | 17. INFORMANT<br><b>John T. Tracey</b>  |  | Address<br><b>Freeland, Md 21053</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4369</b> IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>athero-sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b><br><b>15 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>diabetes mellitus</b>   |  |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-5-</b> , 19 <b>69</b> , to <b>4-7-</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-6-</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did) (did not) view the body after death. |  |   |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Richard Robinson, M.D.</b>  |  |   |   |   | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-7-69</b>                  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD ROBINSON, M.D.</b>  |  |   |   |   | 22e. ADDRESS<br><b>NEW FREEDOM, PA.</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>4/19/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Freeland-Balto.-Md.</b>                     |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>James Hartenstein</b>   |  |   |   |   | ADDRESS<br><b>New Freedom, Pa.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 14 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>05211</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film G411 4/23/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>05203</div>   |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
|--|--|------------------------------|--|--|-----------|---|---|--|--|--|--------------|-------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  |  | Middle    |   | Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR     |                   |  |
| Josephine  |  |                              | R  |  | Trombetta |   |   |  | April 16 1969  |  | 7 A          |                   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |           |   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                              |              | IF UNDER 24 HRS.  |  |
| Female   |  | White                        |  | October 6, 1892  |           |   |   | 17 76 YRS.   |  | MONTHS DAYS                                  |              | HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |           | 9. COUNTY OF DEATH  |   |  |  |  |              |                   |  |
| Italy  |  | USA                          |  |  |           | Baltimore Md.   |   |  |  |  |              |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |              |                   |  |
| Towson   |  |                              | Holly Hill Nursing Home  |  |           | Housewife   |   |  |  |  |              |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE   |  |                              |  | 13b. COUNTY  |           | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |              |                   |  |
| Maryland   |  |                              |  | -  |           | Baltimore,  |   |  |  | 5511 North Charles St                        |              |                   |  |
| 14. FATHER'S NAME  |  |                              | First  |  | Middle    |   | Last  |  | 15. MOTHER'S MAIDEN NAME   |  |              | First Middle Last |  |
| Biaggio  |  |                              | Russo  |  |           |   |   |  | Philomena  |  |              | ? ?               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |  |           | 17. INFORMANT Address   |   |  |  |  |              |                   |  |
| No   |  |                              | 214-36-7533  |  |           | Mrs Josephine Lucas 1564 Dellsway Road 21204  |   |  |  |  |              |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |           |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |              |                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| IMMEDIATE CAUSE (a) Cerebrovascular accident   |  |                              |  |  |           |   |   |  |  | 4 days                                       |              |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ant sel CNS disease   |  |                              |  |  |           |   |   |  |  | 10 yrs                                       |              |                   |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c)   |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |           |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |              |                   |  |
| nom  |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY  |  |           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |              |                   |  |
|  |  |                              | nom  |  |           |   |   |  |  |  |              |                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |           | 21f. LOCATION   |   |  | Street or R.F.D. No.   |  | City or Town |                   |  |
|  |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/4, 1960, to 4/16, 1969, that (I) (we) last saw the deceased alive on 4/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |           |   |   |  |  |  |              |                   |  |
| 22b. SIGNATURE   |  |                              | DEGREE   |  |           | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED   |  |              |                   |  |
| Maurice Feldman  |  |                              |  |  |           |   |   |  | 4/16/69  |  |              |                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              | 22e. ADDRESS   |  |           |   |   |  |  |  |              |                   |  |
| Maurice Feldman Jr M.D.  |  |                              | 6610 Cross Country Blvd  |  |           | Baltimore, Maryland   |   |  |  |  |              |                   |  |
| 23b. DATE  |  |                              | 23c. NAME OF CEMETERY OR CREMATORY   |  |           | 23d. LOCATION (City or Town)  |   |  | (County)   |  | (State)      |                   |  |
| 4/19/69  |  |                              | New Cathedral  |  |           | Baltimore,  |   |  | Maryland   |  |              |                   |  |
| 24. FUNERAL DIRECTOR   |  |                              | 25a. REC'D BY REGISTRAR  |  |           | 25b. REGISTRAR'S SIGNATURE  |   |  |  |  |              |                   |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |  |                              | DATE   |  |           | APR 17 1969 J Charles Jones   |   |  |  |  |              |                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |  |  |       |   |  |   |   |   |  |
|--|--|--|-------|---|--|---|---|---|--|
| 05212  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |       |   |  | 05204   |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First | Middle  | Lost   | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR<br>1:35  |  |
| JAMES  |  |  |       | D.  | TRUMAN   | 4-17-69   |   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAU   |       | 5. DATE OF BIRTH<br>11-02-23  |  | 6. AGE (In years<br>last birthday)<br>45 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>W. VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE CO. Md.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON, MD.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GRTR. BALTO. MED. CENTER        |       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>STEEL   |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>MD.  |  | 13b. COUNTY<br>BALTO   |       | 13c. CITY OR TOWN<br>ESSEX  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>1141 FOXWOOD LANE                             |  |
| 14. FATHER'S NAME<br>JAMES E. TRUMAN   |  |  | First | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME<br>GRACE MYERS TRUMAN  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>UNK   |  | (If yes give war or dates of service)  |       | 16b. SOCIAL SECURITY NO.<br>236-26-7076   |  | 17. INFORMANT<br>EVELYN TRUMAN  |   | Address<br>ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA, EMPYEMA<br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH GAVE<br>RISE TO IMMEDIATE CAUSE (a),<br>stating the underlying cause<br>last. (b) CARCINOMA OF THE LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |       |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>24 HRS.<br>10 MONTHS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |       |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |       | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-22-1969, to 04-17-1969, that (I) (we) last saw the deceased alive on APRIL 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |       |   |  |   |   |   |  |
| 22b. SIGNATURE<br>Richard L. Smith, M.D.   |  |  |       | DEGREE<br>ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>          |   | 22c. DATE SIGNED<br>APRIL 17, 1969                                      |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>RICHARD L. SMITH, M.D.  |  |  |       | 22e. ADDRESS<br>6701 N. CHARLES STREET  |  |   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4/19/69   |       | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO. MD.                                     |   |   |  |
| 24. FUNERAL DIRECTOR<br>Connolly Funeral Home  |  |  |       | ADDRESS<br>300 MALE   |  | 25. REGD BY REGISTRAR<br>APR 21 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 05213  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |                   |   |   | 05205   |  |   |  |  |
| CERTIFICATE OF DEATH   |  |   |                   |   |   |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>William A. Turek</b>  |  |   | First Middle Last |   |   | 2a. DATE OF DEATH<br><b>4</b> Month <b>13</b> Day <b>69</b> Year                                |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |                   | 5. DATE OF BIRTH<br><b>7-29-03</b>  |   | 6. AGE (In years last birthday)<br><b>65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore (Towson)</b> Md.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hosp.</b> |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Maintenance-Sacred Heart Rectory</b>                          |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balta.</b>  |                   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Box 89 Trumps Mill Road</b>        |  |  |
| 14. FATHER'S NAME<br><b>Vaclav Turek</b>   |  |   | First Middle Last |   |   | 15. MOTHER'S MAIDEN NAME<br><b>Katherine Rochac</b><br><b>unknown</b> First Middle Last         |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>no</b>   |  | (If yes give war or dates of service)   |                   | 16b. SOCIAL SECURITY NO.<br><b>215-22-4052A</b>   |   | 17. INFORMANT<br><b>Mary Zika Turek, wife, above</b> Address                                    |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute Extensive Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease</b> |  |   |                   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |                   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>James H. Pungalan</b>   |  |   |                   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-13-69 PM</b>                                |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |                   |   | 22e. ADDRESS  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/17/69</b>   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Shimunek Funeral Home 3331 Bohemia Ld.</b>  |  |   |                   |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1969</b>                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                          |   |   |  |  |   |  |
|--|--|---|--------------------------|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                          |   |   |  |  |   |  |
| 05214 CERTIFICATE OF DEATH 05206   |  |   |                          |   |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>MARIE T. VALENTINE</b>  |  |   |                          |   | 2a. DATE OF DEATH<br>4 Month 30 Day 69 <sup>or</sup>  |  | 2b. HOUR<br>1:28 PM  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |                          | 5. DATE OF BIRTH<br><b>12-29-90</b>   |   | 6. AGE (In years last birthday)<br><b>78</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREAT BALT MED CENTR</b> |                          |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |                          | 13c. CITY OR TOWN<br><b>BALTO.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1600 Mountmor Ct.</b>      |  |
| 14. FATHER'S NAME First Middle Last  |  |   |                          |   | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address<br><b>Thaddeus Valentine 1600 Mountmor Ct.</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4123</b> IMMEDIATE CAUSE (a) <b>CONJESTIVE HEART FAILURE WITH PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MULTIPLE SMALL OLD MYOCARDIAL INFARCTS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEVERE CORONARY ATHEROSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                          |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                          |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   | 12 NOON to 1:30 PM   |  |   |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>4-30</b> , 19 <b>69</b> , to <b>4-30</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>4-30 1PM</b> 19 <b>69</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                          |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Charles C. Brown, M.D.</b>  |  |   |                          |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-30-69</b>                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CHARLES C. BROWN, M.D.</b>  |  |   |                          |   | 22e. ADDRESS<br><b>6701 N CHARLES ST, BALT, MD</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-3-69</b>  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus 4<sup>th</sup> Em. Pk.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>V.R. Bailey</b>   |  |   |                          |   | 25a. REC'D BY REGISTRAR<br><b>MAY 2, 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                     |   |  |
| 26. ADDRESS<br><b>Kelson Funeral Home 1348 Calhoun St.</b>   |  |   |                          |   |   |  |  |   |  |

02512

DATE: 10/10/60

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05215

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05207

|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>ETHEL</b>  |  |  | First<br><b>HOLT</b>   |  |  | Middle<br><b>VIVIAN</b>   |  |  | Last<br><b>VIVIAN</b>   |  |  | 2a. DATE OF DEATH<br>Month<br><b>APRIL</b> Day<br><b>3</b> Year<br><b>1969</b> |  |  | 2b. HOUR<br><b>6:30</b> A.M.                           |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>October 25, 1878</b>   |  |  | 6. AGE (In years last birthday)<br><b>90</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>                         |  |  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore Co.</b> Md.  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>COLLEGE MANOR</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NONE</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>----</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto. City</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>Wyman Park Apts.</b>                              |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>William Edwin Holt</b>   |  |  | First<br><b>William</b> Middle<br><b>Edwin</b> Last<br><b>Holt</b>                                   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Amelia Letitia HOLT</b>  |  |  | First<br><b>Amelia</b> Middle<br><b>Letitia</b> Last<br><b>HOLT</b>                             |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-48-4342</b>   |  |  | 17. INFORMANT<br><b>Dauther:</b> Address<br><b>Balto., Md.</b><br><b>Ethel H.V. Chambers - 204 Ridgewood Rd.</b>  |  |  |   |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable mesenteric thrombosis</b><br><b>4124</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Years</b> |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16/67</b> , 19 <b>67</b> , to <b>4/3/</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>RK Gundry</b>   |  |  | DEGREE<br><b>MD.</b>   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>4/4/69</b>   |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Richard K. Gundry, M.D.</b>   |  |  | 22e. ADDRESS<br><b>2 W. University Parkway, 21218</b>  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  |  |  | 23b. DATE<br><b>4/8/69</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN CO. 108 W. North Av. Balto. 1</b>   |  |  | ADDRESS<br><b>BALTO.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |  |  |  |  |  |  |  |

65215

DEPARTMENT OF STATE

OFFICE OF THE SECRETARY OF STATE

TO: THE SECRETARY OF STATE FROM: THE SECRETARY OF STATE

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

REMARKS: [Illegible]

APPROVED: [Illegible]

SIGNED: [Illegible]

FOR THE SECRETARY: [Illegible]

BY: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

APPROVED: [Illegible]

SIGNED: [Illegible]

FOR THE SECRETARY: [Illegible]

BY: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

APPROVED: [Illegible]

SIGNED: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/62

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |   |  |
|---|--|---|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |   |  |
| 05216   |  |   |   |   | 05208  |  |   |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>—</u> |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |  |   | c. LENGTH OF STAY IN 1b<br><u>1 yr 10 mo.</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>                                 |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Forest Haven Nursing Home</u>  |  |   |   |   | d. STREET ADDRESS<br><u>727 McCabe Ave.</u>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Peter</u> Middle <u>J</u> Last <u>Wallace</u>   |  |   |   |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>12</u> Year <u>1969</u>  |  |   |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>                      |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Mar. 31, 1895</u>                               |   | 9. AGE (In years last birthday)<br><u>74</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Guard</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Pickerton</u> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ireland</u>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>          |   |  |
| 13. FATHER'S NAME<br><u>Patrick Wallace</u>   |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Maria Taylor</u>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>War 1</u>  |  | 16. SOCIAL SECURITY NO.<br><u>219-16-9504</u>         |   | 17. INFORMANT<br>Address (Son)<br><u>Richard P. Wallace 1608 Rosewick Ave. 37</u>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>4109</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rec'd. to Left Hemiplegia</u><br>DUE TO (c) <u>Iron Deficiency Anemia</u> |  |   |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>—</u> a.m. <u>19</u> p.m.   |  |   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>6/29, 1967</u> , to <u>4/12, 1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/12, 1969</u> , and that death occurred at <u>9:00 AM</u> , from causes and on the date stated above.   |  |   |   |   |  |  |   |   |  |
| 22a. SIGNATURE<br><u>John H. Shaw</u>   |  |   |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |  |   | 22b. DATE SIGNED<br><u>4/12/69</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John H. Shaw M.D.</u>  |  |   |   |   | 22d. ADDRESS<br><u>5801 Edmondson Ave. Apt. 28, MD</u>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>4/15/1969</u>                 |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National Cemetery Baltimore, Maryland</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)       |   |  |
| 24. FUNERAL DIRECTOR<br><u>Eugenia K. Seitz 5209 York Road</u><br><u>Seitz Funeral Home Baltimore, Maryland 21212</u>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><u>APR 15 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles George</u> |   |  |

05216

RECEIVED

1951

APR 1 1951



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05217

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05209

|   |  |  |  |   |  |   |  |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Ann</b>   |  | First<br><b>Ann</b>  |  | Middle<br><b>B.</b>   |  | Last<br><b>Wartman</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH Day Year<br>MATED <input type="checkbox"/> 4/27/69 19 8 AM |  | 2b. HOUR<br>8 AM   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>March 1, 1909</b>  |  | 6. AGE (In years last birthday)<br><b>60</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 27 1969</b>   |  | 2d. HOUR<br>9:45 AM  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Colgate</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7205 Woodrow Avenue</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Colgate</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7205 Woodrow Ave.</b>   |  |  |  |
| 14. FATHER'S NAME<br><b>John</b>  |  | First<br><b>John</b>   |  | Middle<br><b>Oechsler</b>   |  | Last<br><b>Oechsler</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Margaret</b>  |  | First<br><b>Margaret</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>213-26-3268</b>  |  | 17. INFORMANT (Husband)<br><b>Charles H. Wartman Sr.</b>  |  | ADDRESS<br><b>Balto. Md. 21224</b>   |  | 7205 Woodrow Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute gastric Hem.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Theodore C. Patterson</b>  |  | EXAMINER'S NAME (Type)<br><b>Theodore C. Patterson</b>   |  | M.D.<br><b>M. D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/30/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  | 22b. DATE SIGNED<br><b>4/28/69</b>   |  | 22c. ADDRESS (Street, city, town, or county)<br><b>3724 Dundalk Ave. Dundalk, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda</b>   |  | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>  |  | 25. REC'D BY REGISTRAR<br><b>APR 30 1969</b>  |  | DATE  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

71320

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |                                    |  |   |   |   |  |
|--|---------|--|--|------------------------------------|--|---|---|---|--|
| 05218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05210  |         |  |  |                                    |  |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |                                    |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |   |   | 2b. HOUR                                     |
| RUTH Ann WATSON  |         |  |  |                                    |  | Month Day Year  |   |   | M  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (in years<br>last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS     |  | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD                | 2d. HOUR                                     |
| female   | white   | 6/9/1941   | 27 YRS.  |                                    |  |   |   | Month Day Year                          | 9:23 p.m.                                    |
| 7a. BIRTHPLACE (State or foreign country)  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |
| Maryland   |         |  | U.S.A.   |                                    |  |   | Baltimore Md.   |   |  |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson   |         |  | St. Joseph's Hospital  |                                    |  | Key puncher   |   |   | Tool Mftg.                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE  |         |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET AND NUMBER  |   |  |
| Maryland   |         |  | Harford  |                                    | Monkton  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     | Box 99 Jarrettsville Pike   |   |  |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME   |                                    |  |   |   |   |  |
| First Middle Last  |         |  | First Middle Last  |                                    |  |   |   |   |  |
| Walter L. Watson   |         |  | Minnie Geib  |                                    |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT  |   |   |   |  |
| No   |         |  | 214-36-8761  |                                    | ADDRESS RD #1, Box 99<br>Walter L. Watson Monkton, Md. 21111   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>7466 Congenital Aortic Stenosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |         |  |  |                                    |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |  |                                    |  |   |   |   |  |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                    |  |   | 20. AUTOPSY?  |   |  |
|  |         |  |  |                                    |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                       |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |  |
|  |         |  | 19   |                                    |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. |  | City or Town  |   | County                                  | State  |
|  |         |  |  |                                    |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |                                    |  |   |   |   |  |
| ACTUAL SIGNATURE   |         |  | M.D.   |                                    |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED                        |  |
| EXAMINER'S NAME (Type)   |         |  | Werner U. Spitz, M.D.  |                                    |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |   | 4/12/69                                 |  |
|  |         |  |  |                                    |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   | ADDRESS (Street, city, town, or county) |  |
|  |         |  |  |                                    |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town) (County) (State)   |   |   |  |
| Burial   |         | 4/15/1969  |  | Bel Air Mem. Gardens               |  | Bel Air, Harford, Md.   |   |   |  |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS                            |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE              |  |
| Charles E. Kurtz   |         |  |  | Jarrettsville, Md.                 |  | 21084   |   | APR 16 1969                             |  |

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1994/95

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DATE: 1-1-48

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100-37171-100

48015

Charles E. Myers, Jr., 194.

# FOR STATE HEALTH DEPT.

05219

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05219

|  |                  |  |  |  |  |  |  |  |                                   |   |  |
|--|------------------|--|--|--|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ELSIE</b>   |                  | First  |  | Middle   |  | Last   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year <b>APR 17 1969</b> |                                   | 2b. HOUR <b>10 P.M.</b>   |  |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>5-14-05</b>  |  | 6. AGE (In years last birthday) <b>63 YRS.</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |                                   | 2c. DATE PRONOUNCED DEAD<br>Month <b>APR</b> Day <b>17</b> Year <b>1969</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>At Home</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>M.D.</b>  |                  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET AND NUMBER <b>8219 BELAIR RD.</b>  |                                   |   |  |
| 14. FATHER'S NAME <b>Ferdinand</b>   |                  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME <b>Matilda</b>  |                                   | First Middle Last <b>Hinck</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) <b>no</b>   |                  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>Dolores Surridge</b> ADDRESS <b>Payettesville, N.C. 932 Country Club Dr.</b>          |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |  |  |  |  |  |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                  |  |  |  |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                   |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County   |                                   | State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |  |  |  |  |  |                                   |   |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>   |                  | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                   | 22b. DATE SIGNED <b>4-17-69</b>   |  |
| EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>   |                  | ADDRESS (Street, city, town, or county)  |  |  |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                  | 23b. DATE <b>4/21/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>   |  | 23d. LOCATION (City or Town) <b>Balto. Md.</b>   |  | County   |                                   | State   |  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>  |                  |  |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR <b>APR 21 1969</b>   |                                   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                             |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1004 J. J. Gray

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |   |  |   |  |
|--|--|---|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>MORRIS WEINER</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 23, 1969</b>  |   |   | 2b. HOUR<br><b>12:10 PM</b>   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>FEBRUARY 5, 1882</b>   |   | 6. AGE (In years last birthday)<br><b>87</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MILFORD MANOR NURSING HOME</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>BROKER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3600 LIBERTY HEIGHTS AVENUE</b>    |  |
| 14. FATHER'S NAME First Middle Last<br><b>GERSHON WEINER</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SOPHIE ?</b> |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>MRS. ANNA BRANCH, 4402 OLD COURT RD., APT. D</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Parkinson's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b><br>Approximate interval between onset and death: <b>2 days</b><br><b>9 years</b><br><b>12 years</b> |  |   |   |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan, 1956</b> , to <b>4/23, 1969</b> , that (I) (we) last saw the deceased alive on <b>4/22, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Isa Zinberg MD</b>  |  |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED<br><b>4/20/69</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ISRAEL ZINBERG</b>  |  |   |   | 22e. ADDRESS<br><b>4001 W. NORTHERN PKWY.</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-24-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHOMRA MISHMERES</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 25 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Isa Zinberg</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or print) <b>Cora</b>   |  |  | First Middle Last <b>Welch</b>   |   |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>19</b> Year <b>69</b>                               |   | 2b. HOUR<br><b>2:45P</b> M                                       |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>4-9-1884</b>   |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove State Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.)<br><b>None</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                 |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>14 S. Tremont Road</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Alawish * Welch</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Emma ?</b>  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT Address<br><b>Spring Grove St. Hosp. records, Catonsville</b>          |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br><b>485X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-12-68</b> , 19____, to <b>4-19</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-19</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert Ludwig MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED<br><b>4-20-69</b>   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 23, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D. C.</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab 3512 Frederick Ave.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 24 1969</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MIDDLE  |  |  |   |  |  |   |  |  |   |  |   |  |
|---|--|--|---|--|--|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |   |  |
| 05222   |  |  |   |  |  |   |  |  |   |  |   |  |
| 05214   |  |  |   |  |  |   |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>EDGAR</b>   |  |  | Last<br><b>WHITE</b>  |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>15</b> Day <b>1969</b> Year      |  | 2b. HOUR P.<br><b>9:45</b> M                                    |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>11/10/1886</b>   |  |  | 6. AGE (In years last birthday)<br><b>82</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CARPENTER</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>                    |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>ANN ARUNDEL</b>   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><b>402 N. Hammonds Ferry Road</b>                 |  |   |  |
| 14. FATHER'S NAME<br>First <b>CHARLES</b> Middle Last <b>WHITE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Sarah</b> Middle Last  |  |  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give dates of service)<br><b>WW-1</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 07 2981</b>  |  |  | 17. INFORMANT<br>Address<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>   |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1621</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNGS AND BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)                                 |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 5</b> , 19 <b>69</b> , to <b>April 15</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 15</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |  |   |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Erhard I. Bunyor M.D.</b>  |  |  | 22c. DATE SIGNED<br><b>4/16/69</b>  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>ERHARD I. BUNYOR, M.D.</b>   |  |  | 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>                        |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>4/18/69</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>WITZKE FUNERAL HOME</b>  |  |  | 24a. ADDRESS<br><b>4101 Edmondston Av. Balto, Md.</b>   |  |  | 24b. REC'D BY REGISTRAR<br>DATE <b>APR 17 1969</b>  |  |  | 24c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |  |   |  |

03882

ARMY AIR OF DEATH

12 1982 12 1982 12 1982 12 1982 12 1982

| NAME    | DATE     | LOCATION | STATUS   | REMARKS |
|---------|----------|----------|----------|---------|
| CHARLES | 12/10/82 | WHITE    | ARMY AIR |         |
| CHARLES | 12/10/82 | WHITE    | ARMY AIR |         |
| CHARLES | 12/10/82 | WHITE    | ARMY AIR |         |
| CHARLES | 12/10/82 | WHITE    | ARMY AIR |         |
| CHARLES | 12/10/82 | WHITE    | ARMY AIR |         |

230 ON 2021 Clinical beds, VA Hospital, Fort Howard, Md.

CANCER OF LUNG AND BRONCHITIS

April 12 1982 April 12 1982 April 12 1982 April 12 1982 April 12 1982

ERNEST I. BRYON, M.D. VA Hospital, Fort Howard, Md.

ERNEST I. BRYON, M.D. VA Hospital, Fort Howard, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05223

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05215

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <u>Frank</u> <u>White</u>  |   |   | 2a. DATE OF DEATH<br>April 15 1969  |  | 2b. HOUR<br>8:00 A.M.   |
| 3. SEX<br><u>M</u>   | 4. RACE<br><u>Cauc.</u>   | 5. DATE OF BIRTH<br><u>Jan. 23, 1878</u>  | 6. AGE (In years last birthday)<br><u>91</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (State or foreign country)<br><u>W. Va.</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><u>Balto.</u>   |  |   |
| 10. CITY OR TOWN OF DEATH<br><u>Parkton</u>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Downes Rd.</u> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Farmer</u>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Farm</u>  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>md.</u>  | 13b. COUNTY<br><u>Balto</u>   | 13c. CITY OR TOWN<br><u>Parkton</u>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><u>Downes Rd.</u>  |   |
| 14. FATHER'S NAME<br><u>Unknown</u>  |   | 15. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>unknown</u>   |   | 16b. SOCIAL SECURITY NO.<br><u>218-18-5929</u>  |   | 17. INFORMANT<br><u>Mrs. Carrie Noyes, Parkton, Md. 21120</u>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 19 <u>62</u> , to <u>4-15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Donald L. Bortner, M.D.</u> DEGREE  |   |   |   | 22c. DATE SIGNED<br><u>4-16-69</u>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>DONALD L. BORTNER</u>   |   |   |   | 22e. ADDRESS<br><u>NEW FREEDOM, PA.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 23b. DATE<br><u>4/18/69</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bethel Presbyterian Cem.</u>                |   |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Jarrettsville-Hartford-Md.</u>   |   | 24. FUNERAL DIRECTOR<br><u>James Hartenstein</u>  |   | 25a. REC'D BY REGISTRAR<br><u>APR 17 1969</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |   |   |  |   |

05383

EXHIBIT 3, CONT.

STATE OF NEW YORK

1960

IN SENATE

JANUARY 12, 1960

REPORT OF THE

COMMISSIONER OF

THE STATE OF NEW YORK

ON THE

STATE OF NEW YORK

FOR THE YEAR 1959

AND

FOR THE YEAR 1960

AND

FOR THE YEAR 1961

AND

FOR THE YEAR 1962

AND

FOR THE YEAR 1963

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>Item 23 phone call 4/11/69 from 05223</div> <div>05223</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>005216</div>  |  |   |   |   |  |  |  |  |  |   |                                   |  |
|---|--|---|---|---|--|--|--|--|--|---|-----------------------------------|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last<br><b>WILLIAM P reston WHITLEY</b>   |  |   |   |   |  | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year<br><b>April 9 1969</b>   |  |  | 2b. HOUR<br><b>1:59 PM</b>   |   |                                   |  |
| 3. SEX<br><b>m</b>  |  | 4. RACE<br><b>w</b>   |   | 5. DATE OF BIRTH<br><b>6-21-1967</b>  |  | 6. AGE (In years, month, day)<br><b>2 3 mos 18</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>4 18</b>  |  | IF UNDER 24 HRS<br>HOURS MIN<br><b>15</b>                   |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St Joseph Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>#21234 8524 Oakleigh Rd. 2</b> |                                   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Harold Whitley</b>  |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Maureen Kathleen Johnson</b>  |  |  |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Harold G. Whitley 8524 Oakleigh Rd. 21234</b>  |  |  |  |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration following choking on Aspirin</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sudden</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |  |  |  |  |   |                                   |  |
| 19a. DATE OF OPERATION  |  |   |   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |   |   | 21b. TIME OF INJURY Month Day, Year<br><b>5:30 am 4/9/69</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Swallowed Aspirin</b>  |  |  |  |   |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b> |   |   |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County State  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |   |  |  |  |  |  |   |                                   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>   |  |   |   | EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>4/9/69</b>                           |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-11-1969</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>                                       |  |  |  | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore Baltimore</b>  |  |   |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>   |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 10 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles F. O'Donnell</b>  |  |   |                                   |  |

1998

7-1-1

• • •

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05225

CERTIFICATE OF DEATH

05217

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ESTELLE M. WIGHT</b>   |  |   | 2a. DATE OF DEATH<br><b>April</b> Month <b>25</b> , Day <b>1969</b> . Year                                    |   | 2b. HOUR<br><b>6 A. M.</b>                       |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>December 19, 1902.</b>   |   | 6. AGE (In years last birthday)<br><b>66</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>4</b> DAYS <b>6</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Box 6, Middle River Rd.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Govt. Worker</b>                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Texas</b>   | 13b. COUNTY<br><b>Rio Hondo</b>  | 13c. CITY OR TOWN<br><b>Rio Hondo</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>Box 103</b>          |  |
| 14. FATHER'S NAME<br>First <b>Thomas</b> Middle <b>Howard</b> Last <b>Howard</b>  | 15. MOTHER'S MAIDEN NAME<br>First <b>Sophia</b> Middle <b>Eichelberger</b> Last <b>Eichelberger</b>            |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT<br>Address<br><b>Mrs. Norma L. Knight, Middle River Road #20</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>4100</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive Cardiovascular Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 hrs.</b><br><b>23 yrs.</b> |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Obesity, Diabetes Mellitus, Gen. Arteriosclerosis</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/30</b> , 19 <b>46</b> , to <b>4/25</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Clifford F. Hudson</b>   |  | 22c. DATE SIGNED<br><b>4/27/69</b>  | 22d. ADDRESS<br><b>FORK, MD. 21051</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>4/29/69.</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 28 1969</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |



13320

STATE OF TEXAS

IN SENATE, FEBRUARY 1, 1907.

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1906.

THE LAND OFFICE  
OF THE STATE OF TEXAS  
HAS THE HONOR TO  
ACKNOWLEDGE THE  
RECEIPT OF THE  
SUM OF FIFTY  
DOLLARS (\$50.00)  
PAID BY THE  
LAND OFFICE  
FOR THE YEAR  
1906.



# FOR STATE HEALTH DEPT.

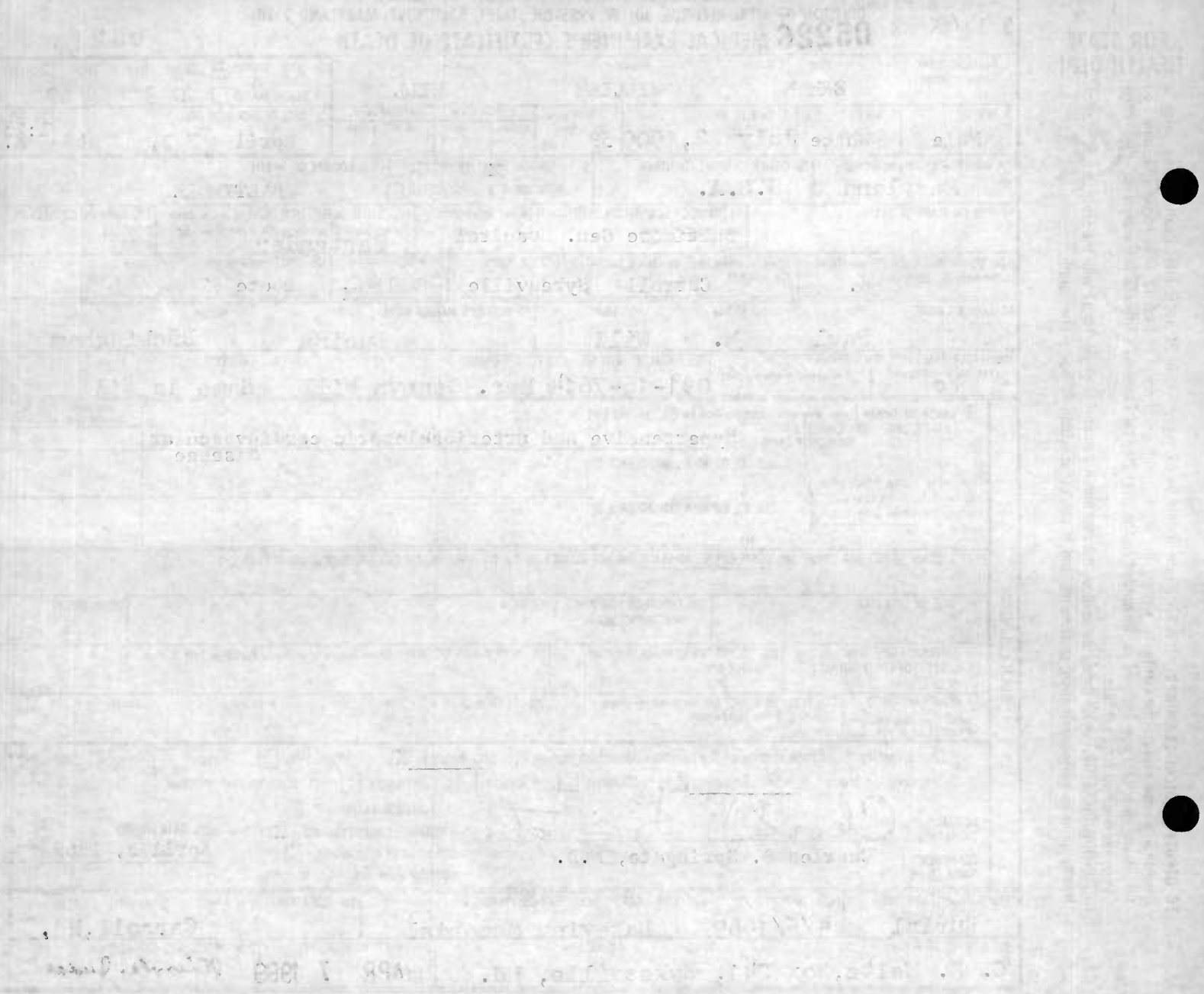
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05218

|  |  |  |  |   |  |  |  |   |  |   |  |                                   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>ERMAN WILLIAM WILL</b>   |  |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year<br><b>4/3 1969</b> |   |  | 2b. HOUR<br><b>M</b>   |  |   |  |   |  |                                   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 22, 1909</b>  |  | 6. AGE (In years last birthday)<br><b>59</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |   |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md. |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore Gen. Hospital</b>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Bartender</b> |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Carroll</b>   |  | 13c. CITY OR TOWN<br><b>Sykesville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  | 13e. STREET AND NUMBER<br><b>Route #2</b> |  |                                   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Paul M. Will</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lucina Buckingham</b> |  |  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>091-16-7614</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Geneva Will Same As #13</b>   |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive and arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |  |  |   |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |   |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |   |  |   |  |                                   |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate, M.D.</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |  |  | 22b. DATE SIGNED<br><b>April 3, 1969</b>  |  |   |  |                                   |  |
| EXAMINER'S NAME (Type)   |  |  |  | ADDRESS (Street, city, town, or county)   |  |  |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/5/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Memorial</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Carroll, Md.</b> |   |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>C. M. Waltz, Box 241, Sykesville, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |   |  |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 05227   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                   |  |   |  | 05219  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <sup>First</sup> <u>Edward</u> <sup>Middle</sup> <u>Henry</u> <sup>Last</sup> <u>Winemiller</u>   |  |   | 2a. DATE OF DEATH <u>April</u> Month <u>9</u> Day <u>69</u> Year |   |  | 2b. HOUR <u>5:30 P.M.</u>  |  |
| 3. SEX <u>M</u>   |  | 4. RACE <u>Cauc.</u>  |  | 5. DATE OF BIRTH <u>Dec. 15, 1891</u>   |  | 6. AGE (In years last birthday) <u>77</u> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Penna.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>Balto.</u> Md.   |  |
| 10. CITY OR TOWN OF DEATH <u>Monkton</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>York Rd.</u>                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Farmer</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>  |  | 13b. COUNTY <u>Balto.</u>   |  | 13c. CITY OR TOWN <u>Monkton</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER <u>York Rd.</u>  |  | 14. FATHER'S NAME <sup>First</sup> <u>Peter</u> <sup>Middle</sup> <u>H.</u> <sup>Last</sup> <u>Winemiller</u> |  | 15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>Mary</u> <sup>Middle</sup> <u>Nading</u> <sup>Last</sup>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <u>28-36-9246</u>  |  | 17. INFORMANT <u>Grace Winemiller, York Rd. Monkton, Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>G. S. C. V. Disease</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><u>Carcinoma of the stomach</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1930</u> , to <u>APR 9, 1969</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>4/8</u> 19 <u>69</u> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>A. M. France</u> DEGREE   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED <u>4/9/69</u>   |  |
| 22d. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>  |  |   |  | 22e. ADDRESS <u>PARKTON, Md.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <u>4/12/69</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Heretford Baptist Cem.</u>  |  | 23d. LOCATION (City or town) (County) (State) <u>Parkton - Balto. - Md.</u>                  |  |
| 24. FUNERAL DIRECTOR <u>James J. Hartenstein, New Freedom, Pa.</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>APR 14 1969</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

02557

CHARTERED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                                       |   |  |   |   |                              |                            |
|---|--|--|---------------------------------------|---|--|---|---|------------------------------|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                                       |   |  |   |   |                              |                            |
| 05228   |  |  |                                       |   | 05220  |   |   |                              |                            |
| 1. DECEASED NAME<br>(Type or print)   |  |  |                                       |   | 2a. DATE OF DEATH  |   |   | 2b. HOUR                     |                            |
| First Middle Last<br>William Stanley Wollschlager   |  |  |                                       |   | 4 Month 16 Day 69 Year   |   |   | M                            |                            |
| 3. SEX  |  | 4. RACE  |                                       | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)                                     |   | IF UNDER 1 YEAR              |                            |
| Male  |  | White  |                                       | 6/20/1894   |  | 74 YRS.   |   | MONTHS DAYS HOURS MIN.       |                            |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                              |                            |
| Baltimore   |  | U.S.A.   |                                       |   |  | Baltimore Md.   |   |                              |                            |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |                              |                            |
| Towson Fullerton (Rural)  |  | St. Joseph Hosp.   |                                       | Chauffer  |  | Cab Co.   |   |                              |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                                       | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER       |                            |
| Md.   |  | Baltimore  |                                       |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | Box 40 8219 Belair Rd. 21236 |                            |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME              |   |  |   |   |                              |                            |
| First Middle Last<br>Thomas Wollschlager  |  |  | First Middle Last<br>Margaret Unknown |   |  |   |   |                              |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.              |   | 17. INFORMANT  |   |   |                              |                            |
| No  |  |  | 217-03-751328                         |   | Box 486 21162 Address White Marsh Donald W. Wollschlager Philadelphia Road |   |   |                              |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                                       |   |  |   |   |                              |                            |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                                       |   |  |   |   |                              |                            |
| IMMEDIATE CAUSE (a) Cardio-respiratory failure  |  |  |                                       |   |  |   |   |                              |                            |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                                       |   |  |   |   |                              |                            |
| (b) Acute Myocardial Infarction + Chronic Emphysema   |  |  |                                       |   |  |   |   |                              |                            |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                                       |   |  |   |   |                              |                            |
| (c) Arteriosclerotic cardio-vascular disease  |  |  |                                       |   |  |   |   |                              |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                                       |   |  |   |   |                              |                            |
|   |  |  |                                       |   |  |   |   |                              |                            |
| MEDICAL CERTIFICATION   |  |  |                                       |   |  |   |   |                              |                            |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                       |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                              |                            |
|   |  |  |                                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   |   |                              |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |                              |                            |
|   |  | HOUR A.M. Month Day Year P.M.<br>19  |                                       |   |  |   |   |                              |                            |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                       | 21f. LOCATION   |  |   |   |                              |                            |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |                                       | Street or R.F.D. No. City or Town County State  |  |   |   |                              |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from April 16, 1969, to April 16, 1969, that (I) (we) lost saw the deceased alive on April 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                       |   |  |   |   |                              |                            |
| 22b. SIGNATURE  |  |  |                                       |   | DEGREE   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                              | 22c. DATE SIGNED           |
| Jamie M. Punzalon   |  |  |                                       |   |  |   |   |                              | 4-16-69                    |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                                       |   | 22e. ADDRESS   |   |   |                              |                            |
| Jamie M. Punzalon   |  |  |                                       |   | 7620 York Road   |   |   |                              |                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                                       | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |   | (County) (State)             |                            |
| Burial  |  | 4-19-1969  |                                       | Parkwood Cemetery   |  | Parkville   |   | Balto. Md.                   |                            |
| 24. FUNERAL DIRECTOR  |  |  |                                       |   | ADDRESS  |   | 25a. DEC'D BY REGISTRAR   |                              | 25b. REGISTRAR'S SIGNATURE |
| Lassahn Funeral Home  |  |  |                                       |   | 7401 Belair Road 21236   |   | APR 21 1969   |                              | James J. J...              |

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THE STATE OF TEXAS

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Joseph H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 6-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |                           |  |
|---|--|--|--|---|---|---|--|---------------------------|--|
| 05229   |  |  |  |   | 05221   |   |  |                           |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR                  |  |
| First Middle Last<br>Paul m NMI Wordtt  |  |  |  |   | 4 Month 12 Day 69 Year  |   |  | 12:20                     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR           |  |
| Male  |  | White  |  | 06/09/03  |   | 65 YRS.   |  | MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                           |  |
| Maryland  |  | USA  |  |   |   | Baltimore Md.   |  |                           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                           |  |
| Randallstown  |  | Balto. Co. Gen. Hosp.  |  |   |   |   |  |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER    |  |
| Md.   |  | Baltimore  |  | Pikesville  |   |   |  | 4111 Priscilla Lane       |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |  |                           |  |
| First Middle Last   |  | First Middle Last  |  |   |   |   |  |                           |  |
| John Wordtt   |  | Elizabeth Bradley  |  |   |   |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address   |  |                           |  |
| Unknown none  |  | 015-03-7222  |  | BCGH records  |   | Randallstown, Md.   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |                           |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |                           |  |
| IMMEDIATE CAUSE (a) CORONARY THROMBOSIS   |  |  |  |   |   |   |  |                           |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |                           |  |
| (b) ARTERIO SCLEROTIC HEART DISEASE   |  |  |  |   |   |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |                           |  |
| (c)   |  |  |  |   |   |   |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |  |                           |  |
| BENIGN HYPERTENSION   |  |  |  |   |   |   |  |                           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                           |  |
|   |  |  |  |   |   |   |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |                           |  |
|   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |  |                           |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | Street or R.F.D. No.  |  | City or Town County State |  |
|   |  |  |  |   |   |   |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1961, to 3-10, 1969, that (I) (we) last saw the deceased alive on MARCH 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |                           |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |   |   |  |                           |  |
| Samuel P. Scaliap   |  | 4-14-69  |  |   |   |   |  |                           |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |   |   |   |  |                           |  |
| SAMUEL P. SCALIAP   |  | 22f. ADDRESS   |  |   |   |   |  |                           |  |
|   |  | 22g. ADDRESS   |  |   |   |   |  |                           |  |
|   |  | 22h. ADDRESS   |  |   |   |   |  |                           |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                                     |  |                           |  |
| Burial  |  | April 14, 1969   |  | Winnet Hills Cemetery   |   | Pikesville, Balto Md.   |  |                           |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. RECD BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |                           |  |
| Frank H. Newell   |  | Pikesville, Md.  |  | DATE 1 6 1969   |   | Charles Judge   |  |                           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |  |  |  |  |  |  |
|--|--|---|---|---|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |   |  |  |  |  |  |  |
| 05230 CERTIFICATE OF DEATH 05222   |  |   |   |   |   |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Middle Last<br><b>SAMUEL B. WRIGHT</b>                        |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>4 30 69</b>  |  | 2b. HOUR<br><b>3:15A M</b>                                 |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br><b>4/4/16</b>   |   | 6. AGE (In years last birthday)<br><b>53</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSP. FT HOWARD, MD.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CHAUFFEUR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CAB COMPANY</b>              |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>WICOMICO</b>  |   | 13c. CITY OR TOWN<br><b>SALISBURY</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1010 Lake St.</b>             |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Perry Wight</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sarah Robinson</b> |   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (known) <b>YES</b> (If yes, give war or dates of service) <b>WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 12 19 70</b>   |   | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSP. FT HOWARD, MD.</b>  |   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RUPTURED ANEURYSM ABDOMINAL AORTA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS GENERALIZED</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |  |  |
| 22a. I certify that (he/she) this hospital) attended the deceased from <b>4/12/69</b> , 19__, to <b>4/30/69</b> , 19__, that (he/she) lost saw the deceased alive on <b>4/30/69</b> , 19__, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.   |  |   |   |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. D. Talbert, MD.</b>  |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>4/30/69</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>   |  |   |   | 22e. ADDRESS<br><b>VAH FT HOWARD, MARYLAND</b>  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/3/ 69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Acres</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury Wicomico Md.</b>               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Clinton F. Stewart</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>STEWART FUNERAL HOME SALISBURY, MARYLAND</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>MAY 5 1969</b>  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05231  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05223

|  |  |   |   |   |  |  |   |  |  |  |  |
|--|--|---|---|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM VICTOR WRIGHTSON</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>15</b> Year <b>1969</b>  |   |  | 2b. HOUR<br><b>3:45 P.M.</b>   |   |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>                     |   | 5. DATE OF BIRTH<br><b>11-12-85</b>   |  | 6. AGE (In years last birthday)<br><b>83</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>3</b> IF UNDER 24 HRS.<br>HOURS <b>3</b> MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>STEEL WORKER RETIRED</b>                 |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STATE MD.</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4833 PARK HEIGHTS AVE.</b>              |  |  |
| 14. FATHER'S NAME<br>First <b>FRANCIS</b> Middle <b>WRIGHTSON</b> Last <b>ALICE DAWSON</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>ALICE DAWSON</b> Middle <b>ALICE DAWSON</b> Last <b>ALICE DAWSON</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown <b>NO</b> (If yes give war or dates of service)                    |   |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-20-2844</b>   |  |   | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>                                       |   |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE, pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Diseases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebrovascular Accident, left hemiplegia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>generalized arteriosclerosis, peripheral vascular diseases</b> |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                      |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  |   |   |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   | 23b. DATE<br><b>4-17-1969</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SPRINGHILL CEMETERY</b> |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>EASTON TALBOT MD.</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>R. ELIUS CLARK</b>  |  |   |   |   |  | ADDRESS<br><b>EASTON, MARYLAND</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DA APR 21 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

Wilson, John

John Wilson

John Wilson, 1000 Ocean Street

John Wilson, 1000 Ocean Street

John Wilson, 1000 Ocean Street



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|---|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |  |  |   |  |  |  |
| 05232 CERTIFICATE OF DEATH 05224  |  |   |   |   |   |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <del>XXXXXXXX</del> Antone NMI  |  |   | First Middle Lost                             |   |   | 2a. DATE OF DEATH<br>4 Month 27 Day 69 Year  |  | 2b. HOUR<br>M                                   |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>3-27-90   |   | 6. AGE (In years<br>last birthday)<br>79 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Balto. Co. Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Co. General |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Line 0 Type |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Self Employed                          |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3547 Milford Mill Rd. |  |  |  |
| 14. FATHER'S NAME<br>John NMI Yienger   |  |   | 15. MOTHER'S MAIDEN NAME<br>unknown Rosenberg |   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220-01-5372 A   |   | 17. INFORMANT<br>Grave Yienger  |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diffuse Pulmonary edema - Respiratory Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic and heave pericarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |   |   |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>HRS<br>MO-YRS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CA of PROSTATE with metastases to lymph nodes</u>   |  |   |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>yes |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Sumner Call, MD   |  | 22c. DATE SIGNED<br>4-27-69   |   | 22d. PHYSICIAN'S<br>NAME (Type)   |   |  |  |   |  |  |  |
| 22e. ADDRESS  |  |   |   |   |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>May 1, 1969  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                 |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers 8728 Liberty Road 21133  |  |   |   | 25. DIED BY REGISTRAR<br>APR 30 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>Judge  |  |   |  |  |  |

02532

TABLE 4.3.10. A SPEE ID CARD